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BALCONY

the JOURNAL
OF THE MEDICAL SOCIETY OF NEW JERSEY

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1967

JULY 1967
VOL. 64, NO. 7

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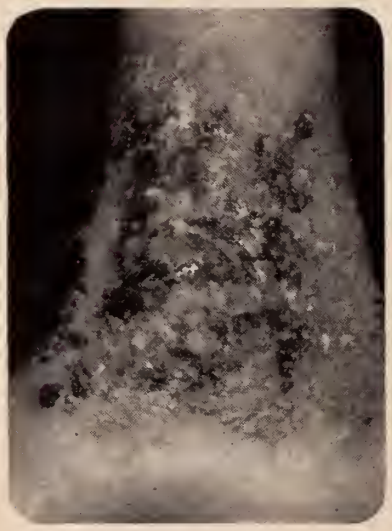
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Desbutal Gradumet contains 2 drugs, each in its own tablet section, combined back to back to form a single tablet. One section contains Desoxyn to suppress the appetite and lift the mood; the other contains Nembutal® (pentobarbital) to soothe the patient and counteract any excessive stimulation. The drugs are released in an effective dosage ratio throughout the day.

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THE PROGRAM

WEIGHT CONTROL BOOKLET



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Here is a partial list of the topics covered:

- Why you are overweight
- Rewards of weight reducing
- Balanced meals
- Helpful hints
- Hunger between meals
- Snacks
- Weekly weighings
- Exercise
- Holidays, vacations, special events
- Leanness and longevity

Each topic is covered on one page in simple and easy-to-understand language. At the back of the booklet, there is a list of 160 foods showing their caloric content.

FOOD DIARY



The Food Diary is designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing everything down that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.

This booklet also lists the caloric content of 160 foods.

See Brief Summary on next page.

THE PRICE

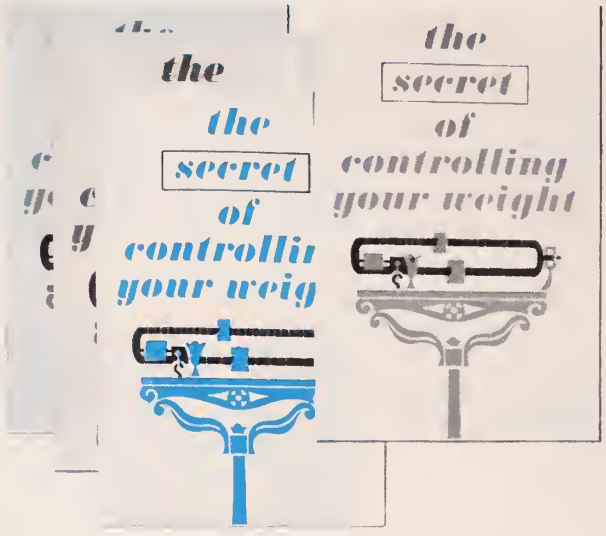
ECONOMY

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

Desoxyn Gradumet and Desbutal Gradumet are so reasonably priced that patients in many cases save enough (compared to other leading long-release anoretics) to get five weeks of medication for the price of four.

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Your Abbott man will be happy to supply you with booklets. Just ask him.

CONTRAINDICATIONS: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

PRECAUTIONS, SIDE EFFECTS: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and addiction.

Amphetamine side effects such as a headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Pentobarbital (in Desbutal) may cause skin rash. Nervousness or excessive sedation with Desbutal is usually transient.

701069

ABBOTT

Gradumet—Long-release dose form, Abbott: U.S. Pat. No. 2,987,445.



New view of an oral contraceptive at work

Although suppression of ovulation remains the primary mode of action of oral contraceptives, newer knowledge indicates that products like Norinyl-1 — which provide the combined action of both low-dosage progestogen and estrogen for the full treatment cycle — offer multiple contraceptive action that helps explain their unexcelled record of effectiveness. This report explores the secondary protective mechanisms against unwanted pregnancy offered by combined hormonal administration and the importance of the progestational agent in making such multiple contraceptive action possible.

Accumulating evidence has indicated that sparse, highly viscous cervical mucus has an adverse effect on the motility and survival of spermatozoa.

The estrogen-opposing progestational ingredient of Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.) reverses the usual mid-cycle picture of a thin, watery cervical mucus. The result — a built-in barrier that inhibits sperm from reaching the ovum should one be released. The inset in the adjoining photograph shows immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

See last page for contraindications, precautions, side effects and dosage.

How the estrogen-opposing action of Norinyl-1 creates a hostile cervical mucus

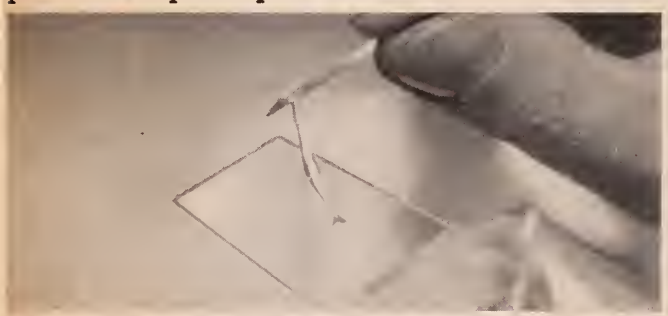
Normally estrogen activity during the fertile midcycle stimulates the production of cervical mucus. The mucus at this time is profuse and watery—allowing maximum sperm motility and promoting penetration.

But what happens when Norinyl-1 is administered? Its potent progestogen, norethindrone, opposes estrogen stimulation of cervical mucus. Consequently, the amount of mucus decreases and its viscosity increases. This results in a sparse but thick mucus barrier that diminishes the vitality of the sperm and impairs its powers of penetration.

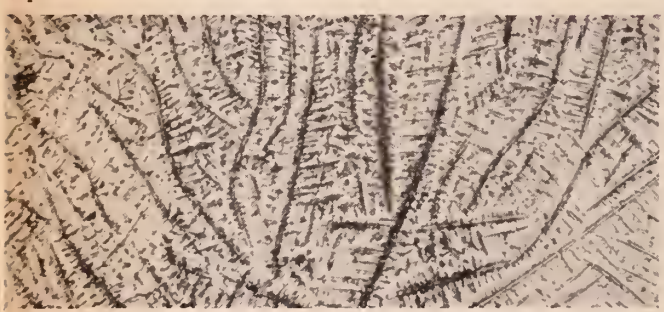
How hostile cervical mucus supports contraceptive action

The importance of these observations to the effectiveness of Norinyl-1 has been noted in a report on 89 patients taking this medication.* In all instances, cervical mucus obtained from cycle day 5 to cycle day 29 appeared scant and thick and exhibited little or no Spinnbarkeit. In the opinion of this investigator, the effect on cervical mucus may be sufficient to prevent conception. *Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965.

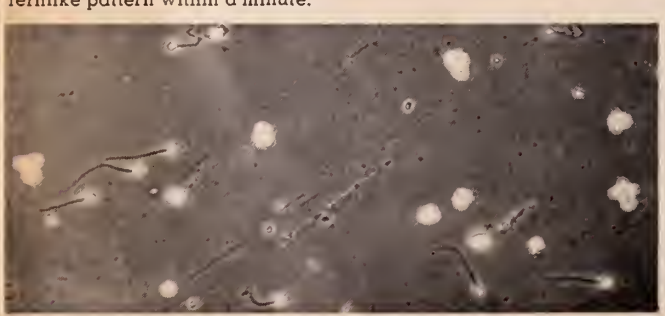
Normal cervical mucus at midcycle in untreated patient permits sperm motility... promotes sperm penetration.



Cervical mucus is thin and watery with a stretchability (Spinnbarkeit) of 15 to 20 cm.



Thin, watery mucus crystallizes into this well-defined, fernlike pattern within a minute.

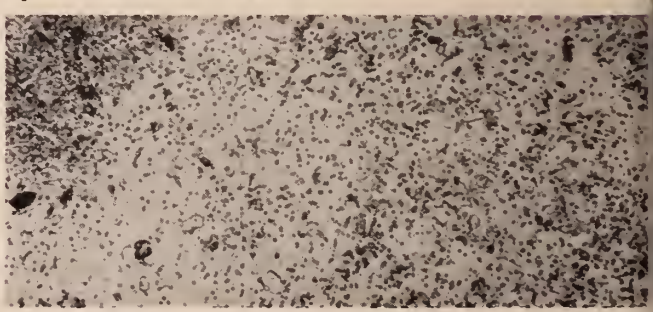


Spermatozoa appear healthy, are active and free moving.

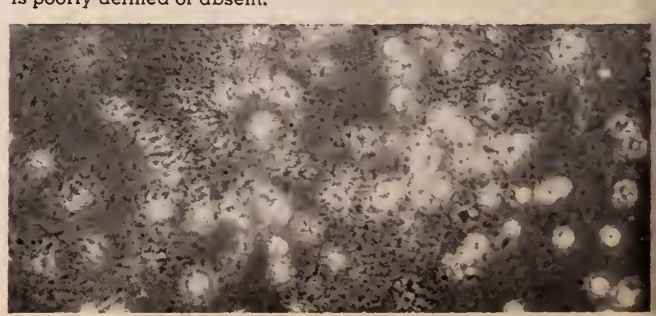
Hostile cervical mucus at midcycle produced by Norinyl-1 impairs sperm vitality... inhibits penetration.



Cervical mucus is scanty, thick and viscous. Spinnbarkeit is 1 cm. or less.



In thick, hostile cervical mucus the fern pattern is poorly defined or absent.



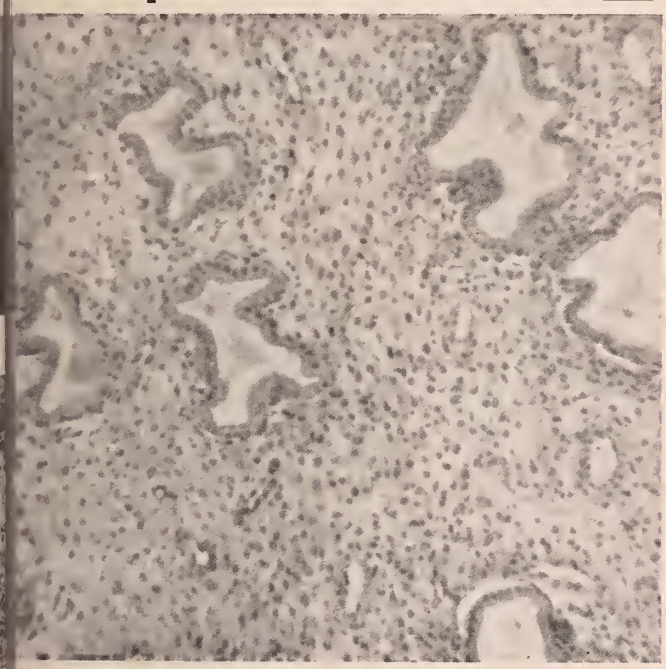
Immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

An endometrium unreceptive to nidation– another supporting contraceptive action of Norinyl-1

.et us suppose that an ovum is released—as occurs in an occasional, rare case—and somehow a sperm succeeds in penetrating the cervical mucus barrier? Should this come about, one additional action of Norinyl-1 may protect the patient from unwanted pregnancy—progestogen intake makes endometrial issue unreceptive to implantation.

ndometrium of
ntreated patient

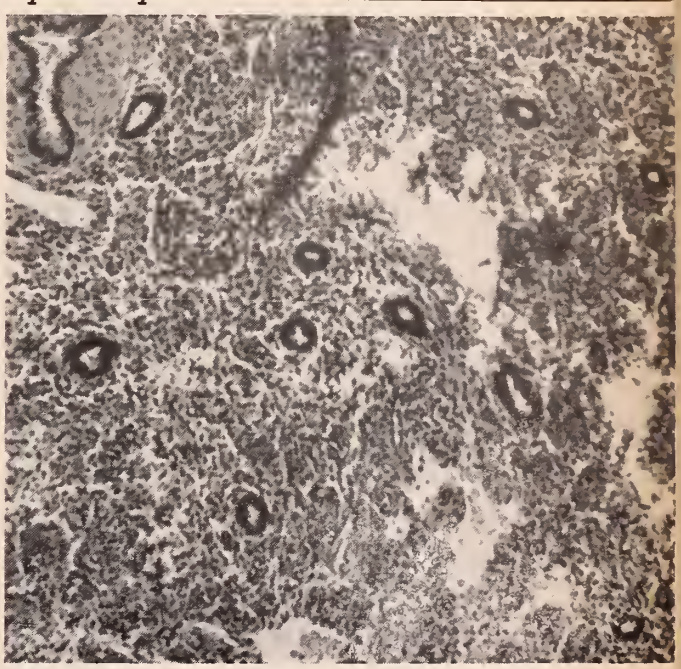




ormally the endometrium progresses through proliferative phase stimulated by estrogen and a ecretory phase stimulated by progesterone. uring the secretory phase the endometrium is ceptive to the fertilized ovum.

Unreceptive
endometrium produced
by Norinyl-1





When Norinyl-1 is administered its progestogen component—norethindrone—accelerates the secretory phase, suppressing glandular development. From day 11 on, secretory action is no longer present. The result is that during the latter half of the cycle the endometrium becomes unreceptive to egg implantation.

e last page for contraindications, precautions, side effects and dosage.

new Norinyl®-1 tablets
(norethindrone 1mg ē mestranol 0.05mg)

for multiple contraceptive action

effective fertility control
on half the previous dosage

maintains ratio
of the established
norethindrone/mestranol
combination

lower cost

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(norethindrone 1mg. & mestranol 0.05mg.)

Reduction of oral contraceptive dosage to lowest effective levels has become a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now available in a new strength in which *both* norethindrone and mestranol are reduced 50 percent. Studies show that Norinyl-1 achieves fertility control with only 1.05 mg. of combined progestogen and estrogen per tablet.

Norethindrone was first reported for use as a progestational agent in human beings in 1955. Norethindrone 2 mg. with mestranol 0.1 mg., as an oral contraceptive, is currently in use by over 2,000,000 women. Clinical experience now establishes that Norinyl-1 also amply meets the criteria of reliability and safety.*

*Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965.

PRESCRIBING INFORMATION

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of Norinyl-1 in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with Norinyl-1. Therefore, if such tests are abnormal in a patient taking Norinyl-1, it is recommended that they be repeated after the drug has been withdrawn for 2 months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibroids may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac, or renal dysfunction, require careful observation. 5. Although a cause and effect relationship has not been established, Norinyl-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, as in all cases of irregular bleeding *per vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged Norinyl-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Norinyl-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. A cause and effect relationship has not been demonstrated. 11. Because of the effects of estrogens on epiphyseal closure, Norinyl-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask the onset of the climacteric. 13. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma, breast changes (tenderness, enlargement and secretion), loss of scalp hair, change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, erythema multiforme, erythema nodosum, hemorrhagic eruption, migraine, rash (allergic), itching, rise in blood pressure in susceptible individuals, mental depression.

The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has not been established: thrombophlebitis, pulmonary embolism, neuroocular lesions.

The following laboratory results may be altered by the use of oral contraceptives: increased bromsulphalein retention and other hepatic function tests, coagulation tests (increase in prothrombin, factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metapyrone test, pregnanediol determination.

Other side effects reported to have occurred in association with use of this drug are dizziness, hirsutism, pains in legs, back, chest and abdomen, dysuria, drowsiness, vaginal discharge, libido increased and decreased, eruptions, hypermenorrhea, hypomenorrhea, increased appetite, G.U. infections, varicose veins, abdominal fullness, acne, headache, nervousness, allergies, blurred vision, pain in eyes, and itching in eyes. *For complete clinical data, see package insert.*

Dosage and Administration: 1. One tablet of Norinyl-1 is administered orally for 20 days beginning on day 5 of the menstrual cycle. (Count day 1 of the cycle as the first day of menstrual bleeding.) Repeat this dosage schedule for each cycle. 2. If no menstrual period occurs after a cycle of treatment (20 tablets) by which patient adhered to the schedule, the patient must be instructed to resume taking the Norinyl-1 tablets 7 days after the previous 20 day course was completed. For example, if the last pill of a previous cycle had been taken on a Sunday, then a new cycle of treatment should begin on the following Sunday. 3. In the postpartum woman, it is recommended that the first cycle of treatment should begin on day 5 of the first menstrual cycle. However, Norinyl should not be administered during lactation.

Availability: Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.)—Dispensers of 20 and 60 and bottles of 250 tablets.

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Maybe he doesn't know when he's well off. But you might want to prescribe long-acting Novahistine LP anyway.

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supplied in ¾, 1½, and 3-grain Pulvule



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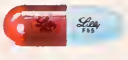
ontraindications: Barbiturates should not be administred to anyone with a history of porphyria, nor should ey be given in the presence of uncontrolled pain, beuse excitement may result.

arning: May be habit-forming.

ecautions: Tuinal should be used cautiously in paents with decreased liver function, since prolongation effect may occur.

dverse Reactions: Idiosyncrasy, such as excitement, ngover, or pain, may appear. Hypersensitivity reactions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.

Overdosage: C.N.S. depression. Symptoms—Depression of respiration and of superficial and deep reflexes, slight constriction of the pupils (in severe poisoning, dilation), decreased urine formation, lowered body temperature, coma. Treatment—Symptomatic and supportive (gastric lavage; intravenous fluids; maintenance of blood pressure, body temperature, and adequate respiration). Dialysis may speed removal of barbiturates from body fluids.



Dosage: 50-200 mg. (¾-3 grains) at bedtime.

[031767]

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Stuart

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FACT & LEGEND

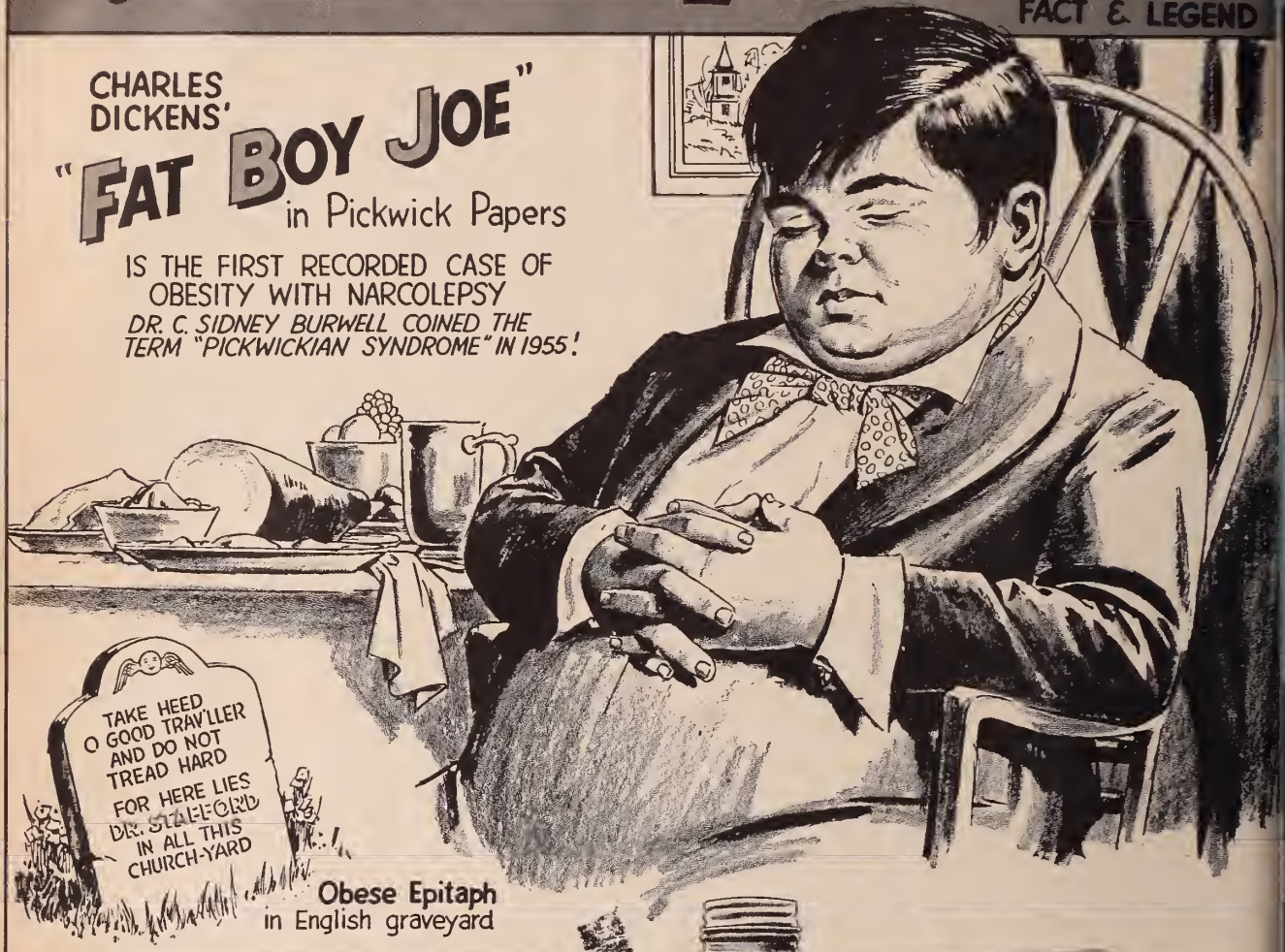
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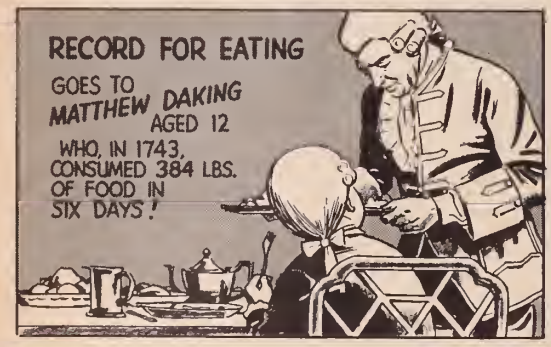
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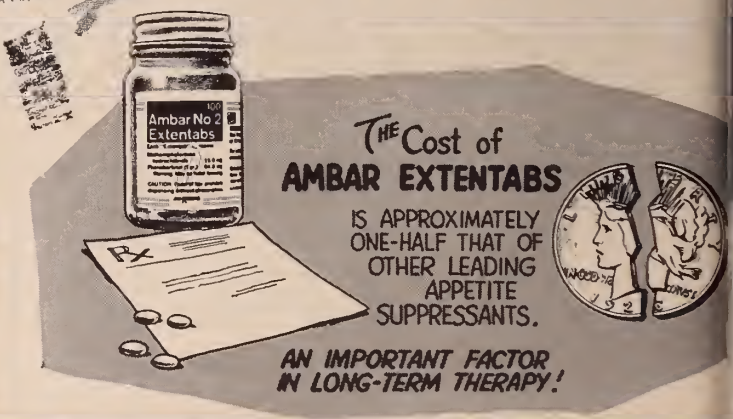
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One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

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butabarbital	25 mg.

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Precautions: Use with caution in cardiovascular or hyperthyroid disease, severe hypertension, circulatory collapse, prostatic hypertrophy, or glaucoma.

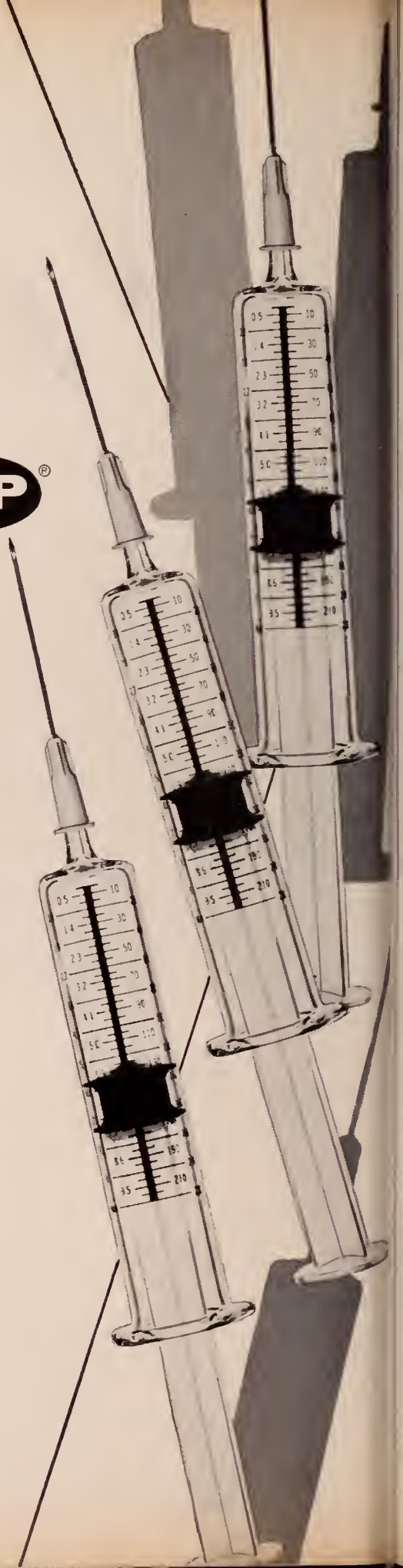
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EDITORIALS

Rural GP: A Vanishing Breed?

A testimonial dinner was tendered a few months ago to Dr. Pierre Nyvall, a member of The Medical Society of New Jersey and the only medical practitioner in Barnegat. In commenting on this occasion, the Beach Haven *Times* discussed the plight of Southern Ocean County — which is typical of many rural areas throughout the Garden State. Here are some extracts from the editorial in that newspaper:

Can you imagine an engineer or an accountant or a chemist or a physicist or an attorney or any other professional man or woman getting out of bed at three o'clock in the morning to practice his profession. Not on your life you can't and neither could he.

Doctors are expected to and they do, and the doctors of Southern Ocean County — a diminishing breed, by the way, not an increasing fraternity — have done at least their share if not more of this sort of thing that many younger doctors in richer communities are getting away from as much as possible.

The cold hard fact is that Southern Ocean County's supply of physicians is going to dwindle to practically nothing if we don't get busy, and probably will even if we do.

While the number of physicians has not grown in the past ten years, the population has, which means more patients per doctor. There are three on the island, three in Tuckerton, one in Manahawkin, one in Barnegat, and one in Bayville.

Efforts have been made by municipal officials, leading citizens and even the doctors to get new physicians to locate in our area. They have been unsuccessful and it is most people's guess that their chances of success are remote.

There are a hundred reasons why you cannot get a doctor to settle in Southern Ocean County, but the chief reason seems to be the same reason they aren't settling in any small towns. Many of them specialize and cluster near the big population areas.

The general practitioners are setting up practices in more affluent areas than Southern Ocean County. The number grows at a far less pace than the population.

The future of medical care in our area is bleak. Some of the doctors here now are past or near retirement time and we would guess that within five years, we will be doing with one or two fewer doctors.

Instead of complaining we should actually be thankful for the dedicated physicians we have in our midst. Their breed may become extinct in our area some day and then we'll really have something to complain about.

The usual answer to a plea like this is to point out that in these days of turnpikes, parkways, and speedy cars, a patient can be brought swiftly to a hospital or doctor's office miles away. However, this does not meet the need of a cry in the night, a swiftly developing emergency in the home or on the farm. The citizens of one rural county have, in this bleak editorial, registered the problem. One would hope that the soaring mind of man (capable, we understand, of getting to the moon, 240,000 miles away) would be able to solve that problem. It we doctors don't find the answer, some other group will try.

AMA Position On Medicare Changes

The American Medical Association favors utilizing medicaid instead of expanding medicare. Dr. Charles Hudson, AMA president, outlined the Association's position at a House Ways & Means Committee hearing on the Administration's bill "Social Security Amendments of 1967" (H.R. 5710).

"Available tax funds should be used to give maximum health care to those who need help." Dr. Hudson said. "Expenditure of public funds on those who do not need help limits the resources available to those who do need it. We believe that a properly administered Title 19 (medicaid section), with realistic criteria of eligibility designed for economically disadvantaged persons, plus the encouragement and improvement of voluntary health insurance and prepayment plans for the solvent, provides the best approach to health care financing.

"Unfortunately, Part B did not receive the public or congressional debate warranted by the scope of the proposal. As a result, congress is now confronted with many problems inherent in the vast undertaking of the federal

government in becoming directly involved in the total health care of almost twenty million persons."

Dr. Hudson said that carriers, physicians, patients, and the government all are dissatisfied with Part B. One possible solution might be to substitute for the Part B program a subsidy to all eligible persons for the purchase of private insurance.

An amendment has been proposed which would provide a new Part C to cover payment for hospital services rendered to hospital outpatients; and for diagnostic specialty services to both outpatients and inpatients of hospitals. The AMA opposes Part C *in toto*.

The AMA endorses the proposal to remove the requirement of a physician's certification for inpatient hospital care for each Medicare patient admitted to a general hospital. The present system causes an unnecessary impediment to the operation of Part A.

Although free choice is guaranteed for Title 18 recipients, a similar privilege is not extended to Title 19 beneficiaries. We believe this was an oversight and urge that it be corrected.

The AMA recommends that Title 18 be amended to permit payment of charges for professional services on the basis of a physician's itemized statement of charges rather than a receipted bill. We recommend the removal of the requirement for three days of hospitalization before qualifying for extended care benefits. Under Title 19, we urge that the program permit payment to the patient for services rendered to him by a physician on the basis of the physician's itemized statement of charges. We suggest that it clearly provides for the payment of physician fees on the basis of his usual and customary charges, using the same approach as that applied under Title 18. We believe that Title 19 should permit all state plans to vary the eligibility standards within a state to recognize the very real differences in the cost of living in a rural area, a small town, a city, or a metropolitan area.

Title 19 benefits differ for mentally ill patients depending on whether they are above or below age 65. We believe there should be no distinction in the services available to mentally ill patients.

Concern For The Handicapped

In a recent talk* to the American College of Cardiology, Dr. Irvine Page, a distinguished clinician and researcher, deplored current interest in artificial organs. "At a time when there is much worry over excess numbers of people and the resultant threat of famine, why this sudden concern for prolonging life by artificial organs? When millions are lacking enough food for subsistence, we exhibit a touching concern for the few who are fatally handicapped. As an experiment, I favor it. As a social phenomenon, I sharply question it."

Perhaps we have misunderstood Dr. Page by taking the one paragraph by itself. We hope so. It seems incredible that any doctor of medicine would question a "touching concern for the few who are fatally handicapped." Does a much honored and much beloved physician really deplore "this concern for prolonging life?"

Primitive people, we are told, let their weak infants and crippled adults die without further attention. This has always been the badge of savagery. Concern for the weak and compassion for the sickly are the traditional hall-marks of a civilized society. It is tempting to consider ourselves the strong and, therefore, the ones entitled to survive. Dr. Page's philosophy reminds one of *Ubermensch* in the Nietzschean sense. But that philosophy was raised on high and tested 25 years ago, and went up in a holocaust of blood, flame, and mushroom clouds. We are not yet ready to give up a faith in the preciousness of life. Superman exists only in the comics.

* Abstracted on page 104 of the April 7 (1967) *Medical World News*.

201st ANNUAL MEETING

Haddon Hall, Atlantic City

MAY 13-17, 1967

Official Transactions Of the House of Delegates

THE MEDICAL SOCIETY OF NEW JERSEY

NOTE TO READERS

The annual reports and transactions of the House of Delegates of the 201st Annual Meeting of The Medical Society of New Jersey are bound together in this issue of THE JOURNAL. Actions taken by the House of Delegates are indicated in bold-face small type.

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ANNUAL REPORTS

President

Joseph R. Jehl, M.D., Clifton

(Reference Committee "A")



In making this final, formal report as the president, I do not propose to recite the details of travel and meetings of the year but rather to speak generally about the many areas of service and of action which have involved my presence and participation as your representative. I am truly grateful for the trust and confidence that you reposed in me and immensely honored by the dignity and responsibility of the high office which by your graciousness I filled. I wish publicly, also, to express my thanks and those of my wife for the warm hospitality and friendliness which everywhere greeted us, especially in connection with our visits to the component societies.

At this time it is also fitting and proper to thank the wonderful people who staff our executive offices for their tremendous help, and to cite them to you for the efficient and generous men and women that they are. We are most fortunate in them because, in consequence of their ability, diligence, and loyalty, we are able to operate not only efficiently but economically.

In common with all of you, I mourn the untimely passing of Mrs. Edith L. Madden, who served the Society for so many years that few of us can remember when first she came. I likewise mourn the death of our former Treasurer, Dr. Daniel F. Featherston, who served the Society well, in many capacities, for many years.

MSNJ is in regular and frequent communication with the American Medical Association, to effect participation in its deliberations and decisions. Our delegates and designated alternates have consistently distinguished themselves by their dedication to the responsibilities which they bear. The record of their commendable activities in behalf of the interests of our Society, and of those of all organized medicine, has been presented in the delegates' reports to the Board of Trustees, and in the summaries of their activities published in the *Membership News Letter.* In addition to the annual and clinical meetings of the AMA, as your president I also attended three special AMA-sponsored meetings in Chicago. Most recently I conveyed to the AMA Board and to the AMA Executive Vice President, the feelings and desires of our members concerning the AMA Disability Insurance Program. You may be sure that we of New Jersey will do all in our power to bring this vexed matter to a satisfactory settlement.

One of the ex-officio honors of the presidency is to become a member of the Boards of both Blue Shield and Blue Cross of New Jersey. I cannot say that one year in such connections has made an insurance authority out of a country doctor, but I did attend and participate in the meetings of both Boards regularly.

As you know, I also testified at the recent Blue Shield rate application hearings in Trenton. The testimony which I there gave was presented in full in our *News Letter,* and I am grateful for the many telephone calls and letters of commendation that I received. At the hearings of the Governor's Committee to

investigate the New Jersey Blue Cross Plan, I was an interested observer.

It has been a great satisfaction and pleasure to meet with more than half of the component societies of MSNJ, both at business meetings and social gatherings. I feel that I can assure you that this part of our organization, too, is in good condition. Twice this year county presidents have met together in our Trenton headquarters and have conferred in joint sessions with the Board of Trustees. The meetings were quite well attended, but I wish to emphasize that it is only through full participation that we will best accomplish our goals. It is a matter of regret to me that I had to forego attendance at meetings of three component societies because of previous commitments — one of which was a "command performance" at the White House, on medical matters.

With the cooperation and sanction of our Board of Trustees, the Academy of Medicine of New Jersey is expanding its programs in the sphere of post-graduate medical education. On the basis of mutual understanding and cooperation we look forward to successful developments.

Our relationships with the two New Jersey medical schools are, I feel, better than ever. In numerous meetings with their faculty representatives, we have established better understanding and have opened what will prove to be, we all feel sure, fuller and more effective channels of communication. My relationships with both faculty groups have been pleasant and fruitful.

Also, in the field of medical education, I must mention the incorporation of the New Jersey Joint Committe for the Implementation of Public Law 89-239 (Heart, Cancer, and Stroke). I have been elected to a two-year term as Committee Chairman, and in that capacity I have been working in close cooperation with all the various societies and groups involved. It has been and will continue to be my aim to see that the basic interests and welfare of patients and their physicians will be mutually well served.

In all areas of contact and concern, in common with my fellow officers, it has been my undeviating purpose to further the principles and objectives which this Society was among the first branches of organized medicine to articulate, for the improvement and protection of its members and the furtherance of the public good.

I thank you for this memorable year. It has been a high honor to serve as the one hundred and seventy-fourth president of this great Society. My services, in other capacities of any kind, are freely yours to command.

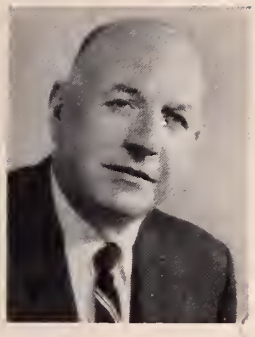
Accepted (page 400)

Live and Learn with New Drugs

There is no simple answer to the question, "How Safe are Drugs?" The effective drugs available today have varying degrees of potentiality for producing harmful effects. Can drugs be developed with such specificity of action that all effects but the one desired would be eliminated? This is something to hope for, but the reactive mechanisms of the body may also have limits of specificity. If we have to live with new drugs which occasionally produce adverse effects, less trouble will occur if the physician uses them wisely. He can do this only by learning as much as possible about them before he prescribes them and then passing along any additional information gained from his own experience.— Ralph G. Smith, M.D., in *Journal of New Drugs,* (6:62-68), January-February, 1966.

Secretary

Marcus H. Greifinger, M.D., Newark
(Reference Committee "A")



The office of the Secretary has continued its usual routines, primarily involving correspondence, telephone inquiries, and completion of numerous questionnaires originating from various sources.

During the administrative year, the Secretary attended the annual meeting of the American Medical Association in Chicago and the Clinical Meeting in Las Vegas – serving in a dual role as MSNJ Secretary and an AMA Delegate. At state level, the Secretary attended the meetings of the Board of Trustees and the several committees of which he is chairman, member, or advisor.

Membership

(As of December 31, 1966)

Active: Paid	6,475	
Exempt	405	6,880*
Associate: Paid	370	
Exempt	60	430*
State Emeritus		186
State Honorary		9
New and Reinstated Members:		
Active	127	
Associate	237	364
Transfers within the state		31
Transfers out-of-state and resignations		61
Members deceased		100
Members dropped:		
Active (non-payment of dues)	27	
Associate (non-payment of dues)	8	35

AMA Membership

A total of 6,281 members of The Medical Society of New Jersey maintain active membership in the AMA. The Society's representation in the AMA House of Delegates continued to total seven delegates – one for each thousand members, or fraction thereof.

Membership Directory

In October 1966, the completion of the 1966-67 edition of the *Membership Directory* was announced. Distribution to the entire membership was made shortly thereafter.

Basically the new *Directory* embodied the same features as that of the 1964-65 edition, which includes:

The supplement section – available only in copies prepared for members – has had added to it the "Basic Concepts Underlying Provision of Professional Medical Care" and several new laws affecting medical practice or medical practitioners. It also contains the Constitution and Bylaws of MSNJ, the AMA Principles of Medical Ethics, the Legal Hazards of Medical Practice in New Jersey, and a list of Poison Control Centers in New Jersey.

Innovations made in this edition include: (1) the presentation in bold print of the "type of practice" in the individual listing directly following the name, and preceding the address; (2) a single asterisk (*) designates "Armed Forces," a single dagger (†) designates associate, and a double dagger (††) designates emeritus membership; (3) the hospital section of the *Directory* includes the staff listing of proprietary hospitals, heretofore not carried.

An expression of gratitude is in order for the cooperation received from the membership in cooperating to produce this *Directory*. The Committee hopes that all members regard this edition as the most complete and serviceable version yet published.

Approved (page 401)

* Adjusted for transfers out-of-state, resignations, and deaths.

Treasurer

Samuel J. Lloyd, M.D., Trenton

(Reference Committee "B")



This 1967 interim report of your Treasurer has been prepared from the books and records of the Medical Society by the Society's outside auditors.

The Balance Sheet is presented as of April 30, 1967 without audit or verification, for the reason that the current fiscal year of the Society does not end until May 31, 1967. Audited figures and a complete report of audit will be prepared and submitted for the fiscal year ended May 31, 1967.

The Statements of Cash Receipts and Disbursements have been prepared, without audit, on a cash basis and do not purport to show the results of operations for the period indicated.

The Statements of Receipts and Disbursements cover the cash transactions in the office of the Treasurer for the twelve months from May 1, 1966 to April 30, 1967. This period comprises one month of the 1965-66 fiscal year and eleven months of the current fiscal year and is so presented in conformity with the suggested form of prior years.

Cash receipts were checked, by the auditor, in full for the period and disbursements checked to supporting vouchers. The cash balances at April 30, 1967 were reconciled with the bank statements but were not confirmed direct with the depositories. Receipts from Counties for dues' assessments were checked in detail to reports on file, but were not confirmed with the County Treasurers at this time.

BALANCE SHEET, APRIL 30, 1967
GENERAL FUND
ASSETS

Cash:		
First Trenton National Bank:		
General Checking Account	$64,890.33	
Executive Office Revolving Account	12,500.00	$ 77,390.33
Savings Accounts:		
First Camden National Bank and Trust Co.	$15,000.00	
First National Bank of Spring Lake	15,000.00	
The Bank of Commerce, Newark	10,000.00	
Bloomfield Savings Bank, Bloomfield	10,000.00	
Broad National Bank, Newark	10,000.00	
First Merchants National Bank, Asbury Park	10,000.00	
The Howard Savings Institution, Newark	10,000.00	
The Morris County Savings Bank, Morristown	10,000.00	
The Montclair Savings Bank, Montclair	10,000.00	
Plainfield Trust Company, Plainfield	10,000.00	110,000.00
Certificate of Deposit, First Trenton National Bank		15,000.00
Savings and Loan Accounts:		
Midtown Savings and Loan, Newark	$10,000.00	
Monroe Savings and Loan, Newark	10,000.00	
Police Savings and Loan, Newark	10,000.00	
Roma Savings and Loan, Trenton	10,000.00	
Guardian Savings and Loan, Atlantic City	10,000.00	50,000.00
Total Cash		$252,390.33
Accounts Receivable—Journal		12,153.73
Inventory of Maternal Record Books (contra)		250.00
Investments—U. S. Treasury Bills		201,783.64
Land, Buildings and Equipment (contra)		161,173.76
Interest Accrued on Investments		2,280.54
1966 History—Bicentennial Deferred Charge		8,229.22
Total Assets		$638,261.22

LIABILITIES, RESERVES, AND SURPLUS

Accounts Payable—Medical Journal	$ 5,328.86
Unexpended budget—1966–67 Fiscal Year	27,315.93
Employees Payroll Deductions Payable	1,912.64
Assessments Deferred to the 1967–68 Fiscal Year	145,157.30
New Jersey Sales Tax Payable	147.38
Library of Academy of Medicine Fund	8,441.25
AMA Dues Payable	6,205.00
AMA Dues Collection Payable	21.70
Annual Meeting Reserve	10,000.00
Maternal Welfare Record Books Reserve (contra)	250.00
House Restoration and Replacement Reserve	4,070.14
Land, Buildings, and Equipment Reserve (contra)	161,173.76
Due to Medical Student Loan Fund	1,730.00
Membership Directory Reserve	11,949.72
General Fund Surplus—April 30, 1967	254,557.54
Total Liabilities, Reserves, and Surplus	$638,261.22

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS GENERAL FUND

May 1, 1966 to April 30, 1967

RECEIPTS

Cash Balance, May 1, 1966					$ 263,316.19
Assessments:	*State Dues*	*AMA Dues*	*Special*	*Total*	
Atlantic	$ 6,626.74	$ 10,090.00	$ 865.00	$ 17,581.74	
Bergen	30,500.30	34,702.50	3,970.00	69,172.80	
Burlington	6,073.39	8,932.50	790.00	15,795.89	
Camden	15,120.15	24,075.00	1,965.00	41,160.15	
Cape May	1,466.70	2,030.00	200.00	3,696.70	
Cumberland	3,706.69	5,365.00	475.00	9,546.69	
Essex	58,500.33	82,610.00	7,480.00	148,590.33	
Gloucester	3,260.04	5,035.00	430.00	8,725.04	
Hudson	19,426.73	26,285.00	2,460.00	48,171.73	
Hunterdon	2,506.68	3,905.00	320.00	6,731.68	
Mercer	15,193.42	24,235.00	1,945.00	41,373.42	
Middlesex	13,866.77	22,247.50	1,790.00	37,904.27	
Monmouth	14,440.15	16,995.00	1,885.00	33,320.15	
Morris	12,806.80	19,872.50	1,675.00	34,354.30	
Ocean	4,500.02	7,110.00	575.00	12,185.02	
Passaic	23,060.09	24,835.00	2,930.00	50,825.09	
Salem	1,760.01	2,915.00	225.00	4,900.01	
Somerset	4,506.73	6,485.00	595.00	11,586.73	
Sussex	1,906.67	2,930.00	240.00	5,076.67	
Union	24,033.49	39,530.00	3,085.00	66,648.49	
Warren	1,493.34	2,285.00	190.00	3,968.34	
Total Assessments	$264,755.24	$372,470.00	$34,090.00	$671,315.24	
Journal Advertising and other Income				$ 59,932.09	
Annual Meeting Exhibits				23,165.00	
Membership Directory Income				7,946.55	
Interest Income				11,925.44	
Sale of Maternal Welfare Books				793.75	
AMA Dues Collection				317.48	
Investments Redeemed (at cost)				290,647.56	
1966 History Reserve Income				1,389.06	
New Jersey Sales Tax Collected (unremitted)				147.38	
Miscellaneous Receipts				16.52	
Total Receipts					$1,067,596.07
Total					$1,330,912.26

DISBURSEMENTS

Budget Accounts:

A — 1 — Executive Salaries	$53,624.30
A — 2 — General Staff Salaries	69,444.17
A — 3 — General Executive Office Expenses	13,726.43
A — 4 — Executive Travel	2,216.85
A — 5 — House Maintenance	11,737.52
A — 6 — Treasurer	4,189.27
A — 8 — Secretary	919.00
A — 9 — Salary Taxes	5,678.07
A — 10 — Insurance	4,640.06
A — 11 — House Reserve	4,555.59
C — 2 — Council on Legislation	3,416.23
C — 3 — Council on Public Health	1,432.60
C — 4 — Council on Public Relations	5,094.31
C — 5 — Council on Medical Services	406.96
D — 1 — President and Presidential Officers	9,539.96
D — 2 — AMA Delegates	8,745.23
D — 3 — Woman's Auxiliary	4,342.07
D — 5 — Conference Groups	11.20
D — 6 — Credentials, Membership, and Directory	22,436.50
D — 7 — Disaster Medical Care	35.40
D — 11 — Medical Defense and Insurance	103.08
E — 1 — Board of Trustees	3,798.18
E — 2 — Contingent	11,717.46
E — 3 — Judicial Council	74.88
E — 4 — Legal	7,354.81
E — 6 — Medical Student Loan Fund	5,000.00

Total Budget Accounts	$ 254,240.13
Journal Publication and Expenses	72,636.14
Annual Meeting Expenses	27,496.56
AMA Dues Remitted	373,015.00
Purchase of U. S. Treasury Bills	270,560.04
Transfer to Medical Student Loan Fund	30,295.00
AMA Educational Research Foundation	206.39
Assessments Refunded	120.02
AMA Dues Collection	2,577.83
1966 History Reserve	38,454.79
Payroll Deductions from Employees—Net	260.03
Library of Academy of Medicine	8,660.00
Total Disbursements	$1,078,521.93
Cash Balance, April 30, 1967	252,390.33
Total	$1,330,912.26

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS
MEDICAL JOURNAL (Cash Basis)

May 1, 1966 to April 30, 1967

Budget Appropriation for Salaries (contra) (Note 1)		$10,679.19
Cash Receipts:		
Advertising—State Medical Journal Advertising Bureau	$42,100.91	
Advertising—Local	11,562.53	
Advertising—Classified	1,306.90	
State Medical Journal Advertising Bureau Rebate	3,227.45	
Subscriptions and Extra Copies	893.08	
Abstracts and Reprints	841.22	
Total Receipts		59,932.09
Total		$70,611.28
Cash Disbursements:		
Publication Costs	$47,012.10	
Illustrations	689.85	
Journal Office Expenses	428.14	
Journal Travel	154.74	
Journal Salaries (Note 1)	14,729.19	
Editor's Insurance	335.76	
Salary Taxes	721.56	
Discounts	1,043.61	
Commissions	2,788.30	
Administrative Expenses	1,115.30	
Solicitation Expense	617.59	
Advertising Manager—State Bureau	3,000.00	
Total Disbursements		$72,636.14
Excess of Disbursements over Receipts		$ 2,024.86

Note 1 Disbursements include a portion of administrative salaries totaling $10,679.19 which were provided for and paid from the General operating budget. These expenses have been shown as part of the Journal operation in accordance with action of the 1963 House of Delegates. No transfer of funds has been made from the General Fund to the Journal operation.

MEDICAL STUDENT LOAN FUND

Balance Sheet—April 30, 1967

ASSETS

Cash:		
First Trenton National Bank		
Checking Account	$12,273.21	
Savings Account	15,000.00	
United Savings and Loan Association, Trenton	15,000.00	
Total Cash		$ 42,273.21
U. S. Treasury Bills (at cost) due 7/27/67 and 8/31/67		58,541.70
Notes Receivable—193 Loans to 114 medical students		182,019.35
Interfund Account—General Fund		1,730.00
Accrued Interest on Investments		663.15
Fund Balance April 30, 1967		$285,227.41

Note—The Fund balance includes $6,302.00 designated as the A. Barker Kump Memorial Grant and $5,030.00 as the Joseph E. Mott Memorial Grant.

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS

May 1, 1966 to April 30, 1967

Cash Balance, May 1, 1966		$ 35,174.28
Receipts:		
Budget appropriation from General Fund	$ 5,000.00	
Contributions—General	4,102.50	
Contributions—Bicentennial commerative	3,700.00	
Contributions—MSNJ Special Assessments	15,315.00	
Interfund transfer—General Fund	14,980.00	
Transfer from Annual Meeting Reserve	1,480.49	
Collection on Notes Receivable	5,425.00	
Interest on Notes Receivable	638.75	
Interest on investments and savings accounts	1,790.29	
Proceeds from investments redeemed	30,000.00	
Total Receipts		82,432.03
Total		$117,606.31
Disbursements:		
Purchase of U. S. Treasury Bills	$58,541.70	
Loans to Medical Students—17 loans	16,500.00	
Insurance Premiums paid for Students	41.40	
Refund for overpayment on note	250.00	
Total Disbursements		75,333.10
Cash Balance, April 30, 1967		$ 42,273.21

Approved, with the recommendation that the Treasurer investigate the feasibility and wisdom of obtaining greater return on investments (page 402)

Board of Trustees

Frank J. Hughes, M.D., Chairman, Camden
(Reference Committee "A")



In accordance with its duties as outlined in the Bylaws, the Board of Trustees has exercised general supervision of the affairs of this Society since the last annual meeting. The Board recorded its regret — as set forth in individual resolutions — in the deaths during the past year of Edith L. Madden, Administrative Secretary-Convention Manager, who so faithfully served MSNJ for 33 years; Dr. Daniel F. Featherston, Treasurer, who held for many years positions of responsibility in organized medicine; Dr. Vincent P. Butler, the 163rd (1955) President of MSNJ; and Dr. L. Samuel Sica, former Board Chairman and AMA delegate. Memorial resolutions adopted by the Board during the administrative year will be submitted as the first order of business at the 1967 House of Delegates for concurrence.

The demands upon the Board of Trustees during this administrative year were sufficiently heavy to require 13 all-day meetings. Board attendance at these meetings was excellent; all Trustees served loyally and diligently. The Board's activities, as will be noted from the following items, have been concerned with specialized areas. Therefore, this report will cover only such items as are not reflected elsewhere in the individual reports of councils and committees.

The Board of Trustees has dealt with matters of all kinds arising out of its responsibilities or brought to its attention, including correspondence and resolutions from members, component societies, the American Medical Association, and outside organizations; appointment of representatives to local, state, and national meetings of concern to MSNJ; nomination of candidates to the State Board of Medical Examiners; action on reports and recommendations of the several standing committees, special committees, administrative councils, and subcommittees; cooperation with the various departments of state government and the allied professions.

Full minutes of all meetings of the Board of Trustees have been mailed regularly to component societies. Summaries of significant actions have been reported in *The Journal*. This report, therefore, will highlight only the major business considered and acted upon by the Board.

In order to reflect the attitudes and opinions of the Board on matters before reference committees, one or more members of the Board have been assigned to each reference committee.

Dr. Emanuel M. Satulsky of Elizabeth (Union County) was re-elected by the Board to continue serving as its Secretary during the past year. Special commendation is due him for his conscientious performance in processing all Board correspondence and meeting notices.

Approved (page 400)

Academy of Medicine of New Jersey

(Reference Committee "A")

At the request of the Academy of Medicine, MSNJ entered into an agreement with the Academy to establish a close working arrangement between the two organizations in all matters relating to medical education. In furtherance of this relationship, MSNJ agreed:

1) To designate three members (at least one of whom shall be an MSNJ trustee) to serve ex-officio as trustees of the Academy, to serve for three years (but may be re-nominated to serve for one additional term);

2) To establish a permanent liaison committee to cooperate in the activities of the Committee on Education of the Academy and the Annual Meeting Committee of MSNJ;

3) To agree that no programs which are not of a purely educational nature shall be scheduled without the full knowledge of both parties, if joint sponsorship is desired;

4) To give publicity to the educational programs and to contribute moral, professional, and financial support of them.

In furtherance of this agreement for closer rapport with the Academy, the Board this year voted to support the request of the Academy that the House of Delegates vote a special $5 per capita assessment for 1968, to be turned over to the Academy for its postgraduate educational program. This information was referred to the Committee on Finance and Budget, for recommendation to the House supplemental).

Approved (page 400)

AMA Membership Dues Increase
(Reference Committee "A")

The 1966 House of Delegates directed that the New Jersey delegates to the AMA disapprove the proposed $25 AMA dues' increase and propose instead a one-time special per capita assessment of $10 to replenish the AMA's operating reserve, with the proviso that disbursements from the fund so accumulated be subject to explicit action of the AMA House of Delegates. Resolution #74 was introduced by the New Jersey delegation at the June AMA (115th) Annual Meeting in Chicago. The issue was hotly debated in the Reference Committee on Reports of the Board of Trustees, and subsequently on the floor of the House, where New Jersey led the fight against the movement for dues' increase and for the adoption of the alternate embodied in its resolution. The campaign was lost by a vote of 117 to 106. The AMA House, by a vote of 168 to 46, adopted the recommendation of the Reference Committee to approve the report of the Board, urging the increase in dues and setting the annual membership dues at $70, effective January 1. New Jersey's resolution was not adopted.

Approved (page 400)

Discrimination in Admission of Physicians to Organized Medicine
(Reference Committee "A")

The 1966 House of Delegates called upon the AMA to effect such changes in its Constitution and Bylaws as might be necessary to assign to the AMA's Judicial Council "the right and responsibility to receive and act upon appeals filed by applicants who allege that they have been unfavorably denied membership in county and/or state medical societies." The New Jersey delegation introduced Resolution #75, embodying the recommended assignment to the AMA Judicial Council (by appropriate amendment of the AMA Constitution and Bylaws) of appellate responsibility and power to deal with complaints alleging unfair denial of membership in county or state societies. Five other related resolutions were introduced from other states. The AMA Reference Committee on Amendments to Constitution and Bylaws offered a substitute resolution (in lieu of the six resolutions submitted) which in all essentials embraced New Jersey's recommendations. The House adopted the substitute resolution.

Approved (page 400)

House of Delegates' Agenda
(Reference Committee "A")

The 1966 House of Delegates, at its first session, adopted the following recommendation for referral to the Board:

That, at least 24 hours before each meeting of the House of Delegates, foreseeable items of agenda be listed and circulated to each delegate of the Society.

The Board recorded itself as of the opinion that as much material as is available is being supplied to all delegates in advance of the annual meeting. At the time the annual reports of various councils and committees are mailed, they are, as of that time, complete. It is necessary to submit to the House certain supplementary reports based on data that are developed after the formal reports have been printed and circulated — and, also, resolutions submitted and information derived from minutes of Board meetings held within

twenty-four hours of the opening of the House of Delegates.

The Board directed that this information be reported to the 1967 House.

Approved (page 400)

Joint Conference With Presidents of Component Societies
(Reference Committee "A")

At the request of component societies, the Board continued to sponsor and arrange informal conferences with presidents of component societies in the Fall and in the Spring. The group elected Dr. Roy T. Forsberg, of Union County, to serve as its chairman for the year. The first conference was held on Sunday morning, October 16, 1966. A total of twenty presidents and/or presidents-elect represented eighteen component societies. The second conference was held on Sunday morning, March 19, 1967. A total of fifteen presidents and/or presidents-elect represented fifteen component societies.

As the result of objection raised by one of the component societies, the Board directed that a survey be taken among all component societies to see if the opinion prevailed that no representation from the Board should be present at the morning conference of the presidents. The results of the survey indicated that only four component societies preferred no Board representation.

At both the Fall and Spring conferences, the conferees met for discussion among themselves in the morning, joined the members of the Board at lunch, and then attended the afternoon session of the Board for discussion.

The presidential group informally discussed many items, all of which were studied and evaluated by individual component societies. Their chairman reported on their discussions to the Board. Some of the areas covered were: (1) programs at local level under the sponsorship of county committees on medicine and religion; (2) caliber of the annual meeting; (3) proposed revision of the Constitution and By-laws in the interest of more equitable representation; (4) Medicare – Part B; (5) the role of county societies in helping organized medicine assume leadership with respect to health care services; (6) the relationship of Medical-Surgical Plan with physicians of New Jersey and MSNJ; (7) the physician's responsibility in influencing the decisions and policies of government at all levels; (8) the Relative Value Scale; (9) Title XIX of the Medicare Law; (10) the role of the county and state societies in aiding members having disputes with administrators of the Federal Medicare Program; (11) absorption of osteopaths into MSNJ; (12) consideration of changes in abortion laws; (13) hospital-doctor relationship; (14)licensure for M.D.'s who have declared intention of becoming citizens.

These conferences have won the enthusiastic approval of both the component societies' leaders and the Board of Trustees. They have been remarked and highly commended by other states and the AMA. Next year it is hoped that it will be possible to invite both presidents and presidents-elect to participate.

Approved (page 400)

Osteopaths in the Armed Forces
(Reference Committee "A")

The 1966 House of Delegates directed that the New Jersey delegates to the AMA solicit the AMA's taking whatever steps are necessary for fully licensed doctors of osteopathy to be taken into service in exactly the same way as are fully licensed doctors of medicine. The New Jersey delegation supported a policy statement submitted by the AMA Board of Trustees, which was subsequently approved in principle by the House. The policy statement declared: "In view of the urgent need for physicians by the Armed Services and in order that all physicians be treated equally and fairly, remembering that 39 states and the District of Columbia offer full licensure to doctors of osteopathy, the Council on National Security recommends that it be the policy of the American Medical Association that

doctors of osteopathy be commissioned in the Armed Forces Medical Services and that this policy be announced at the most propitious time. . . ."

Approved (page 400)

Professional Liability Panel
(Reference Committee "A")

At the request of the Board, the Administrative Director of the Courts rendered a summary report as of March 1, 1966, indicating the Courts' experience in handling claims under the Supreme Court ruling 4:25 B (concerning the use of subpanels on professional liability claims). The Board agreed that the experience of the program should be reported to the 1967 House, for its information and guidance. The summary report follows:

Summary of Proceedings as of February 28, 1967

Requests for subpanels	48
Awaiting consent of doctors	21
Awaiting hearing by subpanels	2
Claims heard by subpanels	17
*Reasonable basis	6
**No reasonable basis	12
Consents refused by doctors	7
Withdrawal of request for panel	7

Since January 1, 1967, there have been 13 requests for subpanels. All are awaiting consents except one case where one of 3 doctor defendants has refused to give his consent.

Status of Cases Where Subpanel Found No Reasonable Basis for Claim as of February 28, 1967

*Total Number of Cases	12
Cases in which no suit was ever instituted	5
Suits pending in court at time of subpanel hearing	6
Suits dismissed after hearing	3
*Suits presently pending	3
Suits instituted after subpanel hearing	1

The Administrative Office of the Courts reported that, as a rule, the reaction to the subpanel hearings has been "good." The Court and the panel members have both experienced by the hearings held thus far. It is the opinion of the Court that it would be beneficial to the subpanel members if the hearings are set up on a permanent basis with set meeting dates. If no claim is to be heard, sufficient advance notice will be given to cancel meetings. Experience thus far has demonstrated the desirability of setting down for the use of subpanels certain standards of procedures to be followed.

The Board was gratified by the results of the report as well as by repeated indications of the attention and interest which it has received at national level. It was unanimous in its commendation of the members of MSNJ whose cooperation thus far has resulted in the successful operation of the Supreme Court Rule.

Recommendation

That the Medical Malpractice Claims Panel Program be continued and that the members of MSNJ be encouraged to continue to cooperate in its furtherance.

Approved (page 400)

Rehabilitation Commission Examination
(Reference Committee "A")

The Board called to the attention of the Division of Employment Security the fact that the fee of $7.50 per examination which now prevails was established in 1948. The Board suggested that consideration be given to the adjustment of this fee, to bring it into conformity with the general increases in the cost of living and in health-care benefits that have developed since 1948. The Rehabilitation Commission susbequently announced that the fee for basic medical examination and report for the vocational rehabilitation program has been increased from $7.50 to $10.

Approved (page 400)

Schedule of AMA House of Delegates
(Reference Committee "A")

Acting on instructions of the Board, New Jersey's delegation to the AMA introduced at the clinical session Resolution #35, urging

* One case had 2 allegations of negligence. Panel found reasonable basis on one count and no reasonable basis on the other.

** In one case in which there are 3 doctors as defendants, one doctor has refused to give his consent.

revision of the schedules of the meetings of the AMA House of Delegates and of its reference committees to allow sufficient time for delegates to study late reports and resolutions in advance of reference committees' meetings and of House sessions at which action is to be taken. The reference committee to which the resolution was referred recorded its sympathy with the intent of the resolution. The AMA House adopted the recommendation of the reference committee that a change in timetable be considered and evaluated for future meetings of the House of Delegates.

Approved (page 400)

The Healing Art
(Reference Committee "B")

The long-awaited bicentennial history of The Medical Society of New Jersey was mailed in September, and delivered as a benefit of membership to all members of MSNJ. Critical comment has been significantly laudatory, and the book has been praised not only for its well-organized and rich content, but for the lively grace of the writing style and the attractiveness of its format. For this distinguished work, MSNJ will ever be deeply indebted to the co-authors: Fred B. Rogers, M.D., one of our members, and Mrs. A. Reasoner Sayre. Since The Medical Society of New Jersey is the first medical organization of its kind in the United States (if not on the North American continent), the chronicle of the beginnings and sequential developments of medical practice and organized medical activities in New Jersey becomes in many instances a record of the foundation and development of medicine in America.

Reaffirmed the commendation of the Board and thanked the co-authors for their outstanding work (page 402)

Project Hope
(Reference Committee "B")

The resolution adopted by the 1966 House calling for the establishment of a maximum of six MSNJ fellowships, to be awarded on a pilot basis for one year, to cover a sixty-day tour of duty aboard the S. S. Hope or her sister-ship, was referred to a special committee. Component societies were notified of the establishment of this project, and the submission of names of potential recipients was invited.

Thus far, only one application has been received. The requested fellowship is for service in April 1968. Unless the program is extended one more year, the current applicant would not be eligible for consideration. The effectiveness of this project is conditioned by the limitations placed upon eligible candidates by the "Hope" organization. Their request is for individuals with specific specialized training and facility in selected foreign languages. These reasons may be responsible for the seeming lack of success of the project up to now.

Recommendation

That the six fellowships created by the 1966 House of Delegates, to be awarded on a pilot basis for one year, each carrying a stipend of $1,000 for a 60-day tour of duty aboard the S. S. Hope or her sister-ship, be extended on an experimental basis for one more year (1967-68).

Approved (page 402)

AID Program
(Reference Committee "C")

The Board — in its 1966 report to the House — recommended that the AID program be continued for another year at least, to afford it sufficient time to prove itself. All authoritative reports thus far indicate that the AID program has continued as an effective instrument for reducing hospital utilization. The accomplished average reduction has been reported as one-half day.

Recommendation

That, in view of the constructive development of the AID Program, the Board of Trustees urges that the program be continued unless

and until it develops defects that are unsatisfactory to the public and the profession. In terms of money, the saving thus far has been estimated as averaging from a minimum of three million dollars to a maximum of five million dollars per year.

Approved (page 404)

Blue Cross Homemaker Project
(Reference Committee "C")

Hospital Service Plan of New Jersey made application to the Department of Health, Education, and Welfare of the Public Health Service for a grant to conduct a Blue Cross Homemaker Health Aid demonstration project in Essex, Middlesex, Morris, and Somerset counties. Endorsement of the project was requested from each of the component societies of the counties involved. One of the component societies solicited the opinion and advice of the Board before giving endorsement to the project.

After review and discussion with representatives of the Hospital Service Plan of New Jersey and the Hospital Association of New Jersey, the Board concluded that it could not endorse the program because it offered a service that:

1) Seemed to embody duplication of services already being supplied by the Visiting Nurses' Association and the Homemakers' Service;

2) Placed the physician in legal and liability jeopardy by asking him to use personnel not legally permitted to him under the Medical Practice Act;

3) Imposed upon the attending physician the responsibility for the control of utilization;

4) Foreshadowed an inevitable increase in subscription expenditures for Blue Cross Plan if it is added to its available coverages;

5) Set levels of compensation for Health Care Aides at at an hourly figure higher than that received by hospital personnel of similar competences, and in consequence might deplete the ranks of present hospital personnel.

The Board supplied the foregoing information to all component societies and requested that they take positions locally on the basis of the action taken by the Board.

Approved (page 404)

Public Hearing on MSP Rate Increase
(Reference Committee "C")

A Public hearing on the application of MSP of New Jersey for a 24.7% subscription rate; increase in its basic contract coverage was held in Trenton on February 9-10. The hearing was called by the Commissioner of Banking and Insurance and was unprecedented in that it featured the participation of a "public defender" who was appointed by the Attorney General at the suggestion of the Governor. By action of the Board of Trustees, MSNJ's President, Dr. Joseph R. Jehl, presented a formal statement in behalf of the Society, urging that the full requested increase be granted. The President's full statement was published in the March issue of the *Membership News Letter*. This particular item is dealt with in detail in the annual report of the Medical-Surgical Plan (see page 369).

Approved (page 405)

MSA Board of Governors — Nominations
(Reference Committee "C")

The following nominations for membership on the Board of Governors of Medical Service Administration for 1967-68 were approved by the Board of Trustees and are referred to the House:

Irving P. Borsher, M.D.
Harry N. Comando, M.D.
Joseph I. Echikson, M.D.
Lloyd M. Felmly
Elton W. Lance, M.D.
Rudolph C. Schretzmann, M.D.
Edward W. Sprague, M.D.
Thomas J. White, M.D.

Approved (page 404)

MSP Board of Trustees — Nominations
(Reference Committee "C")

The following nominations were approved by the Board and are referred to the House of Delegates for action:

Three-year term (1967-1970):

Name	*Type of Practice*	*Member of Component Society*
Jerome G. Kaufman, M.D.	Internal Medicine	Essex County
Joseph P. Donnelly, M.D.	Obstetrics	Hudson County
Edgar P. Eaton, Jr.	Businessman	—
Joseph I. Echikson, M.D.	Internal Medicine	Essex County
Edwin T. Ferren, D.O.	General Practice	—
Mortimer J. Fox, Jr.	Businessman	—
Joseph M. Keating, M.D.	Obstetrics	Passaic County
Elton W. Lance, M.D.	Surgery	Union County
One-year term (1967-1968):		
Samuel J. Lloyd, M.D.	Surgery	Mercer County
Jesse McCall, M.D.	Internal Medicine	Sussex County

Also nominated for membership, to serve during their respective terms of office, are the Chairman of the Board of Trustees of the Hospital Service Plan of New Jersey, the President of the New Jersey Hospital Association, and the President of The Medical Society of New Jersey.

For the record, the following are the remaining members of the MSP Board of Trustees:

Terms expiring 1968	*Type of Practice*	*Member of Component Society*
Edwin H. Albano, M.D.	Pathology	Essex County
Lloyd M. Felmly	Retired Newspaper Editor	—
Theron L. Marsh	Banker	—
Rudolph C. Schretzmann, M.D.	Obstetrics	Bergen County
Charles O. Tyler, M.D.	Pediatrics	Camden County
Thomas J. White, M.D.	Internal Medicine	Hudson County

Terms expiring 1969	*Type of Practice*	*Member of Component Society*
Robert G. Boyd	Hospital Administrator	—
Joseph A. Cox, M.D.	Anesthesiology	Union County
Charles L. Cunniff, M.D.	Internal Medicine	Hudson County
Andrew P. Dedick, Jr., M.D.	Radiology	Monmouth County
Paul M. Forbes	Businessman	—
Warren Simmons	Businessman	—
Sidney I. Simon, Ph.D.	College Professor	—
Robert E. Verdon, M.D.	General Practice	Bergen County

Approved, with the following suggestions for consideration by Medical-Surgical Plan of New Jersey:

1. That the number of terms to be served by the Trustees of Medical-Surgical Plan be limited.

2. That efforts be made to secure "new blood" in the organization and that major changes should not be made primarily because of the death or resignation of a member of Medical-Surgical Plan Board of Trustees.

3. That the Medical-Surgical Plan of New Jersey Board consider the desirability of receiving nominations of physicians for membership on its Board from the Nominating Committee of MSNJ.

The foregoing suggestions are not intended to imply, in any way, that the Trustees of Medical-Surgical Plan have not been commendably diligent in the performance of their duties. **(page 405)**

Health Facilities Planning Council
(Reference Committee "F")

A current report of the financial situation of the Health Facilities Planning Council for New Jersey indicated that unless the Council received support from organizations in the same amount as received last year, it would not be able to obtain sufficient matching funds to support the federal grant. The Board had authorized a one-time $5,000 contribution in 1965 and an additional $5,000 contribution in 1966, with no commitment as to succeeding years, although it was, of course, mindful of the dictum of the 1965 House (Resolution #23) that "The Medical Society of New Jersey affirm its continued support of and membership in the Health Facilities Planning Council for New Jersey."

In view of the new circumstances outlined, the Board voted a $5,000 contribution to the Health Facilities Planning Council for New Jersey.

Approved (page 411)

New Coverage for Over 65 Welfare Recipients
(Reference Committee "F")

As the result of a series of conferences with representatives of the Division of Public Welfare of the New Jersey State Department of Institutions and Agencies, the Board of Trustees on August 21 approved a proposal, submitted by the Division of Welfare of the Department of Institutions and Agencies, governing compensation of physicians for professional services rendered in or out of hospitals to welfare recipients of 65 years of age or more. Hitherto, in-hopsital services have been rendered gratis and out-of-hospital services were compensated on a limited scale. Under the proposal as approved, welfare program limitations relating to the out-of-hospital fixed and inclusive fee schedules, together with the requirement for prior authorization for more than one or two physician visits a month, have been eliminated for the over-age welfare beneficiaries concerned.

The Division, under the approved plan, has "bought in" to obtain coverage under Part B of Title XVIII (Medicare) for approximately 14,000 of its Old Age Assistance clients over 65 years of age who are eligible for such coverage. For other clients over 65 who are ineligible to be covered under Part B through lack of social security entitlement, the Division has arranged to use the Prudential Insurance Company (the New Jersey "carrier" under Part B) as its fiscal agent and to pay through Prudential for the kinds of medical services which are covered under Part B. The result is that all New Jersey Old Age Assistance clients over 65 years of age — whether or not they are in fact enrolled under Part B of Title XVIII — will be covered on the payment principles of Part B, slightly expanded, on a uniform basis.

As reported by the Council on Medical Services, the following are the essential elements of the proposal:

1) A single "carrier" and a single claim form will be used for Part B physicians' services rendered to patients over 65 years of age who are recipients of assistance from county welfare boards, regardless of whether the payment can be made from Part B funds or must be paid for out of welfare funds.

2) Physicians will bill on their regular and customary fee-for-service basis. Bills will be submitted to the carrier and not to the county welfare boards. There will be no fixed schedule of compensation.

3) There will be no requirement for physicians to request prior authorization from county welfare boards for professional services (of the kinds covered under Part B) rendered to such welfare clients over 65 years of age when there is medical need for more than one or two visits per month — as the present program does require.

4) For all such welfare clients over 65 years of age dealt with under this proposal, physicians are asked to accept an assignment. The carrier will, across the board, compensate physicians accepting assignments on the basis of 80% of their regular and customary fees, including the first $50 annually so billed (i.e., the "deductible").

5) Because of the indigency status of the patients covered by this proposal, physicians will be expected not to attempt to collect the remaining 20% from the patients.

6) Under this proposal, physicians will be enabled to receive payment (on the basis set forth above) for services rendered to aged public assistance recipients in hospitals and clinics — which is not so under the present program.

In discussion concerning the proposal, the Board and the Council kept well in mind the House of Delegates action in May 1966, man-

dating – by adoption of a substitute resolution offered by Reference Committee F – "that professional services rendered to patients whose health care costs are the responsibility of governmental or other agencies should be billed by physicians on their usual and customary fee-for-service basis." Under Part B of Title XVIII the attending physician bills on the basis of his usual and customary fees, and that is the stipulated basis for submission of bills under the new welfare proposal.

After careful and extended deliberation, the Board unanimously approved the following recommendation of the Council on Medical Services:

"That MSNJ approve the proposal of the New Jersey State Division of Public Welfare, Department of Institutions and Agencies, in accordance with which New Jersey welfare clients 65 years of age or older – either under the coverage afforded by Part B of Title XVIII (Medicare) or that supplied by the Division out of welfare funds – will be billed by physicians through the Prudential Insurance Company as "carrier" for both groups on the basis of their usual and customary fee-for-service, with the understanding that: (1) 80% of such fees will be paid by the carrier under the principles of payment set forth in Part B of Title XVIII for the compensation of physicians accepting assignments; and (2) there is no commitment to extend the terms of this proposal to the implementation of Title XIX."

Subsequently the Division of Public Welfare adopted the proposal as approved, and announced to all physicians its establishment as a program effective as of September 1, 1966.

At the joint meeting with presidents of component societies in October 1966, the Board's action in approving the recommendation of the Council on Medical Services concerning acceptance of the proposal from the Division of Public Welfare was discussed in detail:

The Board reviewed Resolution #18 from the 1966 House of Delegates. Counsel was asked to make a declaration as to whether or not the action of the Board was in disregard of the principle of the resolution. Legal Counsel declared – as Parliamentarian and Counsel to MSNJ and to the Board – that there was no conflict between the two actions. Under the proposal of the Division of Public Welfare approved by the Board, physicians are free to bill "on their usual and customary fee-for-service basis" – as provided in Resolution #18. Whether or not physicians choose to accept the assignment of the Division of Public Welfare for reimbursement on the basis of 80% of their total bill is a matter of individual choice which each physician must make for himself. The compensation under the proposal takes full advantage of the subsidization available under Part B of Medicare, and adds payment of 80% of the deductible ($50) which Part B imposes. Moreover, it eliminates the requirement that physicians' obtain permission to render repeated services to the covered welfare clients.

The presidents of component societies were unanimous in accepting as completely satisfactory the Board's explanation and the declaration of Legal Counsel.

Approved (page 411)

Consultations by Physicians in Partnership
(Reference Committee "G")

The Board appointed a special committee to review the policy decision adopted in 1963 governing mandatory consultation in hospitals by physicians in partnership, namely:

It is recommended to all New Jersey hospitals that they include a section in their bylaws that, for all consultations that are required by hospital or departmental regulations, the consultant should not be associated economically with the physician who requests the consultation. Specifically, this refers to doctors who practice as partners or as a group, making it mandatory that their consultant be from outside their group when such consultant is available in a given hospital.

In the course of its investigation and study, the Committee made inquiry of the Joint Commission on Accreditation of Hospitals to ascertain whether or not the policy decision of MSNJ was at variance with that of the Joint Committee. The official attitude of the Com-

mission was that, while it frowns on members of a partnership called in as consultants, the best man available, who is well qualified in the field in which his opinion is sought, should be called in consultation. The status of the consultant is determined by the medical staff on the basis of the individual's training, experience, and competence. The Commission recognized that there are occasions when the best man available may be the partner. For this reason, the Commission did not feel that this requirement should be mandatory.

The Board concluded that nothing in MSNJ's policy statement or in the declaration of the Joint Commission makes it impossible for a physician to serve as a consultant to his associate when no other equally qualified consultant is available.

Approved (page 413)

External Cardiopulmonary Resuscitation
(Reference Committee "G")

In cooperation with the New Jersey State Nurses' Association and the New Jersey Hospital Association, MSNJ's Tri-Partite Conference Committee recommended that their parent organizations approve and adopt joint statements on external cardiopulmonary resuscitation, as follows:

External Cardiopulmonary Resuscitation (Including Defibrillation) and the Registered Professional Nurse

In an emergency situation — and in the absence of a physician and until a physician can take over — a registered professional nurse, certified as properly qualified in the technique by the medical board of the individual hospital or some other comparable agency, may initiate the procedures of external cardiopulmonary resuscitation (including defibrillation).

The procedure of external cardiopulmonary resuscitation (including defibrillation) is primarily a medical procedure and, therefore, the decision to delegate this responsibility in an emergency situation to a properly qualified registered professional nurse must be assumed by the medical board of the individual hospital or other comparable agency.

To assure that registered professional nurses are properly qualified to carry out the procedures, hospitals and agencies should provide continuing training programs on external cardiopulmonary resuscitation (including defibrillation) under the direction of a physician officially designated.

Approved (page 413)

External Cardiopulmonary Resuscitation For Properly Qualified Non-Professional Personnel

Preamble:

Cardiac arrest, as used in the following statements, can be defined as the sudden and unexpected cessation of cardiac function, with lack of respiration and absence of effective circulation.

Statement:

Since cardiac arrest can be a totally unexpected event and may happen to an otherwise apparently healthy individual at any time, this accident will frequently occur outside the hospital as well as within its walls. External cardiopulmonary resuscitation should therefore be performed by the first trained and qualified individual (i.e., first-aid squad, police, fire department personnel) who comes in contact with the victim.

Adequate training shall be considered to have been accomplished if the . . .

1) Training course content shall have followed the "Statement by the Ad Hoc Committee on Cardiopulmonary Resuscitation, Division of Medical Sciences, National Academy of Sciences-National Research Council;" and

2) Individual shall have successfully completed the written and practical sections of the New Jersey Health Department Final Examination (M3592). To provide tangible evidence of training, the New Jersey Department of Health is urged to issue wallet cards to those who have satisfactorily passed the courses, following approved procedures, renewable upon re-testing at a predetermined date.

At its meeting on March 19, the Board of Trustees of MSNJ approved and adopted the foregoing statements as recommended.

Approved, with the following recommendation:

That the State Department of Health be encouraged to broaden and expand the instruction and examinaion mechanisms so as to increase the number of properly qualified non-professional personnel. (page 413)

Heart Disease, Cancer, and Stroke
(Reference Committee "G")

Early in the administrative year, Joseph R. Jehl, M.D., MSNJ President, was elected chairman of the Board of Trustees of the New Jersey Joint Committee for Implementation of P.L. 89-239 (heart disease, cancer, and stroke federal legislation).

The Board of Trustees of the Joint Committee is limited to five officially-designated persons who signed the papers of incorporation of the New Jersey Committee in behalf of the five incorporating agencies: New Jersey Divi-

sion of the American Cancer Society; New Jersey Association of Osteopathic Physicians; New Jersey Heart Association; New Jersey Hospital Association, and The Medical Society of New Jersey.

An Executive Committee was likewise established, to consist of the five members of the Board of Trustees, plus one member from each of the following agencies: the Academy of Medicine of New Jersey, the New Jersey College of Medicine and Dentistry, the Rutgers Medical School, the New Jersey State Department of Health, and the New Jersey State Department of Institutions and Agencies.

The Joint Committee prepared an application for a planning grant for a New Jersey program to effectuate P.L. 89-239. It sought to establish a program in New Jersey as a geographical unit, with emphasis upon postgraduate presentations to acquaint and instruct New Jersey physicians with recent discoveries and technical advances in the treatment of victims of heart disease, cancer, and stroke. The initial planning grant application was denied. The Committee is in process of preparing a revised application, which will be resubmitted.

MSNJ's representative has reported that a trend seems to be developing for the establishment in New Jersey of diagnostic and treatment centers for heart disease, cancer, and stroke, in conjunction with one of the medical schools — probably the New Jersey College of Medicine and Dentistry. Resolution #24, adopted by the 1965 MSNJ House of Delegates, placed the Society on record as supporting the American Medical Association in resisting the establishment of diagnostic and treatment centers at local levels. The Board is committed to sustain the Society's position. The funds sought under the planning grant application will be used only to underwrite the administrative procedures of the planning operation.

Approved (page 414)

Mixing of Obstetrical/Gynecological Patients

(Reference Committee "G")

Through the Medical-Hospital Liaison Committee, the Board recorded itself as approving the plan of mixing obstetrical and gynecological patients in hospitals under strict observance of the recommended criteria therefor.

Approved (page 414)

Council on Mental Health

(Reference Committee on Constitution and Bylaws)

The recommendation of the 1966 House of Delegates that the Special Committee on Mental Health be elevated to the status of an administrative council was referred to the Committee on Revision of Constitution and Bylaws to prepare proper amendment to the Bylaws. This item is covered in the Committee's report (see page 332). Until such time as the House is in a position to act on the appropriate amendment to the Bylaws, the Board directed (May 18, 1966) that the Special Committee on Mental Health be elevated, *pro tem,* to the status of an ad hoc committee reporting directly to the Board, with power equal to that of the four administrative councils provided in the Bylaws.

Approved (page 418)

Procedure of Election

(Reference Committee on Constitution and Bylaws)

The 1966 House of Delegates directed that the entire subject of the recommended revision of the Constitution and Bylaws as proposed by the Union County Medical Society concerning the procedure of election (Bylaws, Chapter V) be referred to the Board for further study by a committee that would include members of the Standing Committee on Revision of Constitution and Bylaws. The reference committe realized the depth of the problem but believed that the conclusions of

the study could be completed and recommendations made at the 1967 Annual Meeting.

The Board appointed an ad hoc study committee, as outlined by the House. This committee subsequently submitted the following recommendations, which were approved by the Board (December 18, 1966).

1) That a reapportionment of voting strength within the Nominating Committee, as proposed in the (1966) Union County amendment, is not desirable because the populous counties — in consequence of their greater number of delegates — can proportionately influence the election itself and thus have a strong impact upon the choice of elected officials of the Society. To modify the present voting balance within the Nominating Committee might lead to discouragement of nominees from small counties and result in nominations from the floor that would unnecessarily lengthen the election sessions of the House of Delegates.

2) That an apportionment of county representation by redistricting the entire state is unacceptable because it would unnecessarily jeopardize other aspects of the organization and operation of the Society.

3) That the Morris County resolution to abolish the office of the "Eleventh Trustee" be approved.

4) That each Judicial District be represented by two Trustees for a membership up to 1,000, and that each Judicial District be entitled to one additional Trustee for each additional 1,000 members or major fraction thereof.

The Board referred the appropriate recommendations to the Standing Committee on Revision of Constitution and Bylaws, with the request that necessary amendments be prepared for submission to the House. These items are covered in detail in the report of the Committee on Revision of Constitution and Bylaws (see page 332).

Approved, with the following recommendation:

That the entire matter of reapportionment of representation on the Nominating Committee be returned to—and studied in depth by—the Committee on Revision of Constitution and Bylaws, for subsequent report to the House. (page 419)

Supplemental Report

MSP Coverage for National Accounts

(Reference Committee "C")

At its meeting on May 12, the Board of Trustees — after due deliberation — voted unanimously to support the recommendation in the supplementary report of Medical-Surgical Plan of New Jersey with reference to the coverage that will involve the "prevailing fees" for national accounts.

Approved, with the suggestion of the reference committee that the entire situation should be reviewed by the House at the 1968 annual meeting, for the purpose of critical evaluation in the light of the year's experience. (page 406)

A Portable Pharmacy?

A complete, transportable pharmacy that can be set up on frigid arctic wastes or in steaming jungles is being developed by North American Aviation Corporation for the U.S. Army Surgeon General's Office. A contract has been awarded to the Corporation's Space and Information Systems Division to develop a prototype of the field pharmacy; this would be used with the Army's MUST hospital. MUST stands for Medical Unit, Self-contained, Transportable.

To be delivered in the spring of 1968, the pharmacy will be a collapsible medium-size shelter with facilities for stocking and storing 400 to 500 different pharmaceuticals, a water-purification unit, a refrigerator and even a sink.

It will be transportable by ground, water, or air over all kinds of terrain and operable in temperatures ranging from minus-65-degrees F. to 120-degrees F.

Judicial Council

E. Vernon Davis, M.D., Chairman, Mount Holly
(Reference Committee "A")



The Judicial Council was gratified by the action of the 1966 House of Delegates in reminding all members of MSNJ that "it is incumbent upon each physician to be familiar with the Principles of Medical Ethics, since ignorance of the Principles will not release him from liability before the Judicial Council." Each year, as part of its annual report, the Judicial Council takes great pains to stress the obligation of members to become familiar with the judicial mechanism and their responsibilities to organized medicine in conjunction with it.

The judicial mechanism was created by mandate of the MSNJ House of Delegates. As such, it offers itself as a means whereby differences and disagreements in the areas of ethical and professional conduct can be brought informally to a settlement that is fair to the interests of all parties. MSNJ Bylaws require that the Judicial Council *shall* "receive complaints or accusations from any source concerning the professional conduct or ethical deportment of members of this Society for immediate reference to the appropriate county judicial committee. The quality of the complaint has no bearing on whether or not it is considered worthy of acceptance by a county judicial committee as long as it involves matters of medical ethics or professional conduct. The "Regulations" governing the judicial mechanism — provided for in MSNJ's Bylaws — specifically state that, if a complaint cannot informally be resolved amicably, a hearing *shall* be scheduled by the judicial committee, which the principals are invited to attend. Under the judicial mechanism, judicial committees have the authority to summon members of MSNJ to appear and to testify at such hearings. Disregard of such a summons is tantamount to a charge of unethical conduct and may result in a member's censure, suspension, or expulsion by a county medical society's judicial committee.

The Council re-emphasizes that members are obliged to respond to, and cooperate with, the judicial committee of their component societies. Ignorance of the judicial mechanism does not in any way excuse the fact that members are subject to the disciplines of both county societies and MSNJ. Adequate opportunity is presented at all levels for members to become acquainted with the judicial mechanism.

From the official files, the Council here presents a summary of its operations and those of its county judicial committees for the period extending from April 1, 1966 through March 31, 1967:

By Judicial Committees

Complaints reported as disposed of	54
Alleging:	
Dissatisfaction concerning fees	33
Unethical conduct	3
Dissatisfaction with services rendered	9
Unprofessional conduct	8

By the Judicial Council

Meetings held	6
Official communications acted upon	13
Appeal hearings requested	3
granted	1
pending	1
Formal opinions rendered	2

1) Concerning the ethical acceptability of the Prudential Insurance Company's refusal — as Carrier under Part B of Medicare — to pay a physician for the professional services rendered by him to his mother

2) Regarding the "legality and ethics" of services in connection with the Life Extension Institute

The foregoing opinions are presented in full as an appendix to this report.

Conference with County Committees

In reviewing the items which would have made up the agenda of the Fall conference of judicial committee chairmen, the Council agreed that the circumstances of the mechanism at that time (November) did not seem to warrant a special meeting. The Council took the opportunity, through an official letter, formally and gratefully to commend county judicial committees for the good they have achieved thus far and to urge them to continue dealing promptly and fully with each complaint. County judicial committee chairmen were personally urged to do all that they could to establish and maintain efficiency in the operation of their county society's judicial mechanism.

Opinions

1) Concerning the ethical acceptability of the Prudential Insurance Company's refusal—as Carrier under Part B of Medicare — to pay a physician for the professional services rendered by him to his mother

In reviewing the details of the correspondence in this matter, the Council unanimously agreed that no ethical principle was involved and that the member-physician requesting the opinion had come to erroneous and inaccurate conclusions on the basis of correspondence which he received from the American Medical Association and the Prudential Insurance Company. The correspondence indicated that, contrary to stipulation of the Medicare Law, the member expected to be paid under Part B for professional services which he rendered to his mother.

As Carrier under Part B of Medicare, it is the function of the Prudential Insurance Company to make disbursements only on the basis of stipulations set forth in the law and the regulations related thereof. Title I of Section 1862 of the Medicare Law (P.L. 89-97) — "Exclusions from Coverage" — declares:

(a) Notwithstanding any other provision of this Title, no payment may be made under Part A or Part B for any expenses incurred for items or services . . .

(11) Where such expenses constitute charges imposed by immediate relatives of such individual or members of his household. . . .

It is on the basis of the foregoing section of the Medicare Law—which prohibits payments to relatives of Medicare-covered beneficiaries for professional services rendered — that Prudential based its rejection of the member's claim.

The Judicial Council was unanimous in its opinion that, in view of the unambiguous language of the Medicare Law, the Prudential Insurance Company had no alternative but to reject the member's claim.

The Council took this occasion to point out that the Principles of Medical Ethics obligate only members of organized medicine. Thus, even were the present matter embraced by the Principles of Medical Ethics, no jurisdiction could have been exercised over the Prudential Insurance Company as Carrier under Part B of the Medicare Law.

2) Regarding the "legality and ethics" of services in connection with the Life Extension Institute

The aid and guidance of the Council were requested by a component society as to whether or not an arrangement involved either feesplitting or the corporate practice of medicine.

Informal inquiry through the American Medical Association disclosed that Life Extension Institute was established in 1925. It has several medical directors. No attempt is made by the physicians who perform the examinations to treat the persons involved. The New York County Medical Society is reported to have done extensive research in the area, and none of its findings gives indication of anything unethical in the procedures involved. Reference was made to the following most recent opinion by the Judicial Council of the American Medical Association in this regard:

Executive Physical Examinations

A physician selected by a company can do health ex-

aminations of its employees when the company pays for such services (American Medical Association Judicial Council, 1963).

After reviewing the situation in detail and the information before it, the Council unanimously concluded that it is not unethical for a physician to act as a local examiner for the Life Extension Institute, under the terms outlined in this particular case.

Approved (page 401)

Executive Director

Richard I. Nevin, Trenton

(Reference Committee "A")



Each year April brings to us, with the first flowers of Spring, the task of estimating the harvest of our year's activities as an organization. The reports of the Society's work and the attainments of the administrative year are gathered together for us all to review and evaluate, so that we may know accurately what in the proximate past we have accomplished, and, in the light of that knowledge, plan for the year upon which we are about to enter.

The administrative year of 1966-67 was vigorously demanding from the start. With loins girt, we waited the anticipated bruising struggle to preserve freedom and dignity for physicians and patients alike under the impact of Medicare. The results thus far reflect more embarrassingly upon government than upon the profession of medicine. The physicians seem to be meeting such added demands for care as have developed, but government is encumbered by procedural snarls of its own complicated devising, and faced by an overwhelming heavy cost beyond its published estimates and anticipations.

The year soon brought us both grief and challenge in the area of staff operations. After a long illness, Mrs. Edith L. Madden died in early July, and her passing left a great gap in our hearts and in our working arrangements. The situation was intensified by the resignation, shortly thereafter, of Edith's first assistant and intimate co-worker, Mrs. Marion Walton. We lost another valuable secretarial assistant when in early Fall, Mrs. Lois Stump took employment nearer to her home. Then, Mr. John Barber, our caretaker and maintenance man for the better part of two decades, decided to resign because of the burden of his years. Obviously replacements were needed and readjustments on a wide scale.

Mr. George K. Degnon was engaged as an Executive Assistant to the Executive Director in early July. Miss Theresa E. Goeke, who had been serving splendidly in the demanding double-capacity of Executive Assistant to the Executive Director and Assistant Editor of *The Journal,* decided to surrender the Assistant Editorship and return to full engagement as an Executive Assistant. She and Miss Diana Pleva, who was advanced to secretarial status, have been carrying on, with distinguished competence, the staff work that Mrs. Madden and Mrs. Walton had formerly done in conjunction with the Board of Trustees and its official activities. Mrs. Walton agreed, on a part-time basis, to assume the role and responsibilities of Convention Manager. Mrs. Marjorie Treptow, a staff secretary before her marriage, returned as Editorial Secretary to the Editor of *The Journal,* and has proved herself, once again, of high competence and dependability. In the person of Mr. Harold Lippincott, we found a successor to Mr. Barber.

With the help of all those named and the fine cooperation of all our other staff mem-

bers, we reorganized and closed ranks. We were fortunate to be able to make the necessary adjustment. We have a staff of which, as Executive Director, I am immensely proud, and to whom I am deeply grateful for their distinguished abilities, diligence, and loyalty. Wholeheartedly I bless them all. For them I bespeak the Society's commendation.

The record clearly discloses the leadership and generous service of all our officers, Board members, and council and committee chairmen and personnel. The individual annual reports before the House demonstrate the full measure of devoted service that all rendered in order that the business of the Society might be painstakingly attended to. The Board, under the chairmanship of Doctor Hughes, set an example of diligence for all to follow. Doctor Jehl gave so unstintingly of his time and abilities that I had not occasional fears that the well of his energies would run dry. No one could possibly have covered more ground and attended more meetings than did he. Certainly he has an abiding satisfaction in the knowledge that his was a big job that was well done.

As my part in the Society's operations, apart from my routine duties, my diary discloses that I took part in 174 conferences and meetings of all kinds — in and out of the executive offices — visited 10 component societies, presented 10 talks, and made 4 trips out of state on Society business.

Through the year communications with our component societies have, I think, been better than ever. The conferences of presidents, held in October and March, continue to prove a highly valuable means of authoritative discussion and exchange. This year we initiated an administrative work-shop conference with secretaries/executive secretaries of component societies. The innovation proved fruitful and popular to all who participated. It is our expectation to continue such get-togethers, in the interest of improved understanding and cooperation.

The developments that took place in our Society last year are far more encouraging than the developments that took place in our country and throughout the world. Judging by the past — the recent past — it is difficult for the average citizen to look to the future with anything but trepidation. It is not overwhelmingly solacing, in view of the trend of government in the last two-score years, to recall the passage in the Declaration of Independence which proclaims that all men "are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty, and the pursuit of Happiness" and "that to secure these rights, Governments are instituted among men, deriving their just powers from the consent of the governed."

Our government seems more intent in securing us than our rights. It levies on our lives, progressively restricts our liberty to use our lives and the rewards of our own efforts as we choose, and by thus acting greatly interferes with our personal pursuit of happiness. The blessing of security that our government now seems bent on imparting is to immobilize us as free men. We fear and resist this in the profession of medicine, but the plight in which we find ourselves is only a specialization of the plight that oppresses all our citizens.

Whatever lies ahead, it behooves us as educated and aspiring men and women of unintimidated spirit, to live unswervingly in conformity with principle and with honor . . . to be, in Goldsmith's phrase "too firm in the right to pursue the expedient." If we so live and labor, we will be serving well not only ourselves and the profession, but all our fellow-citizens and our country. Robert Browning describes what each of us should be:

"One who never turned his back but marched breast forward,
Never doubted clouds would break,
Never dreamed, though right were worsted, wrong would triumph,
Held we fall to rise, are baffled to fight better, sleep to wake."

We have, in medicine, thus marched for a very long time. It is an honor, in this spirit, to be marching with you.

Approved (page 401)

Standing Committees

Annual Meeting

Jerome G. Kaufman, M.D., Chairman, Maplewood
(Reference Committee "H")



In July, the Committee met to develop plans for the 1967 meeting in accordance with the several referrals from the 1966 House of Delegates and the Board of Trustees.

The 1966 House disapproved a resolution which called for the House to meet on three consecutive days: Saturday, Sunday, and Monday. The 1967 schedule for the House sessions will revert to that which was followed in 1965 — 1st session on Saturday; 2nd session on Sunday; and 3rd session on Tuesday.

In compliance with a suggestion of the 1966 House "that the Annual Meeting Committee try to get less conflicting scheduling for the 1970 convention by such means as having the time of the meeting advanced; and furthermore, that the Annual Meeting Committee investigate the apparent shortage of hotel staff to handle the heavy traffic of incoming and outgoing guests," the Executive Director and your chairman met during the summer with Haddon Hall executives in an effort to evolve a possible solution to the heavy traffic problem. In order to accommodate the Trustees driving to Atlantic City for the Friday evening Board meeting, advance arrangements will be made to park their cars in a parking lot adjacent to Haddon Hall. It is hoped that these arrangements will enable those Trustees arriving in late afternoon to leave their cars and proceed directly to the convention office, where the keys to their rooms will be available for them.

Requests were received by last year's Board for the formation of two new scientific sections: (1) Section on Plastic and Reconstructive Surgery and (2) Section on Mental Retardation.

Relative to the first request, a resolution from the Board appears on page 389 of these printed annual reports.

The second request was referred to the newly-expanded Special Committee on Mental Health.

By utilizing Haddon Hall's new Pennsylvania Room in 1966, it was possible to seat the House of Delegates — by district by county — in schoolroom set-up for the 2nd and 3rd sessions. This same arrangement will hold for 1967.

The advance program was mailed in February, in the hope that members would find the program outline sufficiently interesting for them to make early arrangements to attend the meeting. The combined scientific section programs are of such a diversified nature this year as to appeal to all specialties. In addition to the membership, the advance program was mailed to New Jersey, Philadelphia, and New York City hospitals and medical schools, and to the editors of journals of all medical societies in the United States.

The final program, which will be distributed to all who register at the convention, will be dedicated to the memory of Mrs. Edith L. Madden, late Convention Manager and Administrative Secretary.

Again this year, because of the growing importance of Medicare to physicians, a General Session on Medicare will be held on Sunday, immediately following the election session of the House of Delegates. Participants

will include representatives from The Prudential Insurance Company of America (carrier for Part "B" of Title XVIII), the Social Security Administration, and the New Jersey State Division of Public Welfare.

The scientific, informational, and technical exhibits total 117 this year.

The Mead Johnson Laboratories will present its "Aesculapius Award" to the author of the most outstanding scientific exhibit. The award will be a certificate, suitably inscribed with the title of the exhibit and the author's name, and a $200 cash prize donated by Mead Johnson Laboratories. The winner will be determined by a Committee of MSNJ.

Seven joint scientific sessions are scheduled for Monday morning and afternoon; two sections are scheduled to meet singly on Wednesday morning; and one section (Radiology) elected not to meet in 1967.

In accordance with a suggestion made several years ago, this year the specialty societies were invited to co-sponsor with MSNJ the scientific programs. Several indicated an interest. The Society of Pathologists has arranged a special program on "Computers in Medicine" to be presented on Tuesday; the New Jersey Allergy Society will present honorariums to those guest speakers appearing before the Joint Session on Allergy, Gastroenterology and Proctology, and Pediatrics; and the New Jersey Orthopaedic Society will hold its spring meeting on Monday morning. A luncheon will follow, immediately preceding the Joint Session on Anesthesiology, Orthopedic Surgery, and Surgery.

Ciba Pharmaceutical Company will sponsor a Motion Picture Theatre, which will schedule showings on Monday, Tuesday, and Wednesday mornings; and Monday and Tuesday afternoons. The films selected will tie in with the general theme of the scientific session programs.

In cooperation with the Academy of Medicine of New Jersey, the New Jersey State Department of Health, the New Jersey State Department of Institutions and Agencies, and the New Jersey Society of Pathologists, special scientific programs will be presented on Tuesday, May 16, running concurrently with the final session of the House of Delegates.

Fifty-one distinguished speakers will participate in the scientific sessions scheduled for Monday, Tuesday, and Wednesday.

The House of Delegates has already approved the following annual meeting dates, which have been confirmed with Haddon Hall:

202nd annual meeting — Saturday-Wednesday, May 18-22, 1968
203rd annual meeting — Saturday-Wednesday, May 17-21, 1969
204th annual meeting — Saturday-Wednesday, May 16-20, 1970

Approved (page 416)

Medicare Lengthens Hospital Stay

Average length of hospital stay for Medicare patients in the nation's community hospitals increased for the fifth consecutive month in December 1966 according to statistics appearing in the March 1967 issue of HOSPITALS. The survey indicates that the over-65 age group had an average length of stay of 13.3 days per admission in December while the under-65 patients held relatively constant at 6.8 days. Since July 1, 1966, when Medicare became effective the average length of stay for the over-65 group has increased from 11.2 days in July to 12.5 in September to 13.3 days in December. The study is based on data from a sample of 628 hospitals selected from a universe of 5684 community hospitals.

Scientific Program*

George J. Kohut, M.D., Chairman, Perth Amboy
(Reference Committee "H")



A joint meeting of the Committee on Annual Meeting with the Officers of the Scientific Sections was held in October 1966, to formulate the scientific programs for the 1967 Annual Meeting.

For 1967, the following sections agreed to combine for presentation of six scientific sessions:

Allergy, Gastroenterology and Proctology, Pediatrics (Monday)
Clinical Pathology, Medicine, Rheumatism (Monday)
Obstetrics and Gynecology, Urology (Monday)
Anesthesiology, Orthopedic Surgery, Surgery (Monday)
Cardiovascular Diseases, Chest Diseases, General Practice (Monday)
Ophthalmology, Otolaryngology (Monday)

The Section on Psychiatry and Neurology will also meet on Monday; and the Sections on Dermatology and Metabolism will present separate programs on Wednesday morning.

The Section on Radiology elected not to meet in 1967.

Four special scientific programs have been scheduled for presentation on Tuesday, May 16, to run concurrently with the final session of the House of Delegates. These programs will be presented by the Academy of Medicine of New Jersey, the New Jersey State Departments of Health, and of Institutions and Agencies, and the New Jersey Society of Pathologists.

A total of 51 outstanding speakers will participate in the scientific programs at the 1967 annual meeting.

In conjunction with MSNJ's annual meeting, the New Jersey Orthopaedic Society will hold its spring meeting and scientific program.

Approved (page 416)

Scientific Exhibits*

Milton Ackerman, M.D., Chairman, Atlantic City
(Reference Committee "H")



The Committee took the following action during the year 1966-67:

1) The Committee distributed application blanks for the Scientific Exhibits to the general mailing list of hospitals, medical schools, and medical organizations in all of New Jersey, Philadelphia, and New York City. These were mailed to the chiefs of major hospital departments and the heads of sections in the medical schools.

2) The Committee, at the request of the Board of Trustees, reinstituted a Motion Picture Exhibit for the 1967 meeting. The Committee obtained a sponsor, and selected and scheduled suitable films.

* Subcommittees of Annual Meeting Committee

3) The Committee accepted the invitation of Mead Johnson for MSNJ to participate in their "Aesculapius Award Program." This program provides for an award of a suitable plaque and a $200 cash prize donated by Mead Johnson Laboratories and designated as the Aesculapius Award, to be awarded the Scientific Exhibit which was designated by the judging committee to be the most suitable one under eligibility qualifications established by the Committee for this award.

4) To provide for easier access to, and better circulation through, the exhibit area, the Committee obtained the approval of the Annual Meeting Committee for entrances at both ends of the Exhibit Hall.

5) The Committee selected suitable exhibits in medical, surgical, and informational categories from the applications which were submitted.

Approved (page 416)

Credentials

Marcus H. Greifinger, M.D., Chairman, Newark

(Reference Committee "A")

The Committee on Credentials throughout the year reviewed and acted upon membership applications and their supporting credentials as submitted through the component societies.

The following statistical breakdown reflects the Committee's activities during the period April 1, 1966 to March 31, 1967.

	Associate	*Advancement to Active*	*Active*	*Total*
Received	235	192	47	474
Reviewed and found:				
Satisfactory	214	184	41	439
Unsatisfactory	0	0	0	0
Pending	21	8	6	35

The committee again expresses appreciation to the officers of component societies for their cooperation.

Approved (page 401)

Honorary Membership

F. Clyde Bowers,* M.D., Chairman, Mendham

(Reference Committee "H")

No nominations were submitted this year to the committee. Consequently, no meetings were held during this administrative year.

* Deceased, April 22, 1967

Accepted (page 416)

Finance and Budget

Thomas C. DeCecio, M.D., Chairman, Cliffside Park
(Reference Committee "B")



A review of the expenses of the first ten months of the current administrative year and an estimation of the expenses for the final two months indicate that the individual budget accounts are sound.

The Journal

The anticipated *Journal* deficit has decreased, for the third consecutive year. This can be attributed to several factors: (1) an unanticipated increase in the volume of advertising supplied both by SMJAB and our local agent; (2) a general advertising rate increase of 15% across the board effective July 1, 1966; (3) and another satisfactory year with Periodical Press, which has been able to print *The Journal* more economically than has hitherto been possible.

The anticipated deficit for publication of *The Journal;* Journal Salaries, including the editor and editorial secretary; Journal Office expenses and travel; editor's insurance and salary taxes; editorial secretary's salary taxes; and other Journal expenses will be charged off to the unexpended balance in the budget accounts at the end of this fiscal year. A net surplus will still result in the 1966-67 total budget.

Approved (page 402)

"Project Hope"

Although there were no fellowships granted to date on "Project Hope," there are two applications pending.

For 1967, your committee recommends, with concurrence of the Board of Trustees, that the House of Delegates authorize continuation for another year the provision for six (6) Fellowships, each carrying a stipend of $1,000, totalling $6,000.

Approved (page 402)

Special Per Capita Assessment

For 1967, the 1966 House of Delegates voted a special per capita assessment of five dollars ($5.00) — to serve as a contribution to the Medical Student Loan (50%) for use as loans in 1966-67, to the Bicentennial Fund (25%), and to the Library of the Academy of Medicine of New Jersey (25%) — to apply equally to all dues-paying members, with no reduction for associate members as in the past, and to be levied in addition to, and not as part of the budgetary assessment, with both being paid at the same time.

The 1966 House of Delegates approved your committee's recommendation that any surplus monies from the Bicentennial Fund be turned over to the Library of the Academy of Medicine — with compliance postponed until after the Bicentennial year was over (December 31, 1966), when the Bicentennial financial situation would be reviewable and any excess monies would be readily determined. In reviewing this House action, your committee submits a statement of actual revenues and expenses through March 31, 1967 on the Bicentennial Year. (page 318)

Recommendation

For 1968, your committee recommends, with the concurrence of the Board of Trustees, that the 1967 House of Delegates vote a special per capita assessment of five dollars ($5.00) to serve as a contribution to the Academy of Medicine of New Jersey for postgraduate edu-

cation programs of the Academy; and that it apply equally to all dues-paying members. Your committee further recommends that the special per capita assessment be levied in addition to, and not as part of, the budgetary assessment, with both being paid at the same time.

Approved, with the following recommendation:

That the Academy of Medicine make known to the general membership details of all postgraduate educational facilities which are offered. (page 402)

BICENTENNIAL STATEMENT ON
ACTUAL REVENUE AND EXPENSES
THROUGH MARCH 31, 1967

Revenue through March 31, 1967:			
(1) Bicentennial Fund			$24,055.09
(2) History Reserve (6/1/64)			10,000.00
(3) Income from sales of *The Healing Art*			1,329.06
TOTAL Revenue			$35,384.15
Expenditures through March 31, 1967:			
1) *Fiscal Year 1964-65:*			
(a) Mrs. A. R. Sayre (1/65)			$ 1,010.85
2) *Fiscal Year 1965-66:*			
(a) Mr. T. Makin (9/65)	$ 1,000.00		
(b) Miss E. H. Ruggles (9/65)	25.00		
(c) Mrs. A. R. Sayre (11/65)	2,756.48		
(d) Mr. Homer Hill (2/66)	1,000.00	4,781.48	
3) *Fiscal Year 1966-67:*			
(a) Mrs. A. R. Sayre (9/66)	$ 2,000.00		
(b) Nat'l Publishing (9/66)	1,475.00		
(c) Wise Tag & Label (9/66)	17.83		
(d) N. J. Historical Soc. (9/66)	3.50		
(e) Register Copyrights (9/66)	6.00		
(f) Promotional Expense (10/66)	60.82		
(g) Postage on Formal Announ. (10/66)	132.75		
(h) Livermore & Knight Co. (3/67)	34,638.11	38,334.01	
4) *Miscellaneous Expenses:*			
(a) Mailing Cost on Sales	$ 72.00		
(b) Supplies	35.96		
(c) Meeting & Luncheon	4.94	112.90	
TOTAL Expenditures			$44,239.24
Deficit balance as of 3/31/67			($ 8,855.09)

1968 Assessment

The computation of cash surplus at the close of the current fiscal year is estimated at $249,736.22 — 66% above the $150,000.00 sum which has been indicated as the desired surplus amount at the beginning of each new fiscal year.

In accordance with Chapter X of the Bylaws, the dues year is January 1 to December 31, and the fiscal year is June 1 to May 31. The administrative year including the budget, which controls expenditures, is based on the fiscal year. It therefore becomes necessary to apportion the 1967 and 1968 per capita assessment to the 1967-68 fiscal year on the basis of 7/12 of the 1967 assessment for the new fiscal year soon to commence (June 1, 1967) and 5/12 of the 1968 assessment for the latter part of that fiscal year starting January 1, 1968.

The proposed budget for 1967-68 is $288,-217.00; 7/12 of the 1967 assessment applicable to this proposed budget is $151,060.64. This leaves $137,156.36 to be raised by 5/12 of the

1968 assessment. On the basis of 6,384 paid members as of May 31, an assessment of $51.57 per capita will be necessary in 1968 to raise this amount — 5/12 of $329,222.88 is $137,176.20. However, since the estimated cash surplus as of May 31 is 249,736.22 and the desired minimum cash surplus at the close of each fiscal year has been set at $150,000.00, the 1968 assessment can remain at $40.00 per capita by applying $30,776.20 from surplus toward the amount to be raised. $137,176.20 less $30,776.20 leaves a net amount of $106,-400.00 to be raised. 6,384 members paid at $40.00 is $255,360.00, 5/12 of which is $106,-400.00. The net cash surplus at May 31 will then be $218,960.02.

Approved, with the following recommendation:

That the 1968 Assessment be adopted at $40 per capita with no provision for a contribution to AMA-ERF. (page 403)

ACCOUNT	CURRENT 1966–67 BUDGET	FOOT-NOTES	PROPOSED 1967–68 BUDGET
A – 1 — Executive Salaries	$ 69,328.00	(1)	$ 62,365.00
B – F — Journal Salaries	12,050.00	(2)	—
A – 2 — General Staff Salaries	68,124.00	(3)	79,874.55
A – 3 — General Executive Office Expense	14,200.00	(4)	14,400.00
A – 4 — Executive Travel	3,610.00	(5)	2,780.00
A – 5 — House Maintenance	13,470.00	(6)	15,670.00
A – 6 — Treasurer	4,190.00	(7)	4,770.00
A – 7 — Finance & Budget	75.00		75.00
A – 8 — Secretary	400.00		400.00
A – 9 — Salary Taxes	5,487.00	(8)	6,037.45
A – 10 — Insurance	5,725.00	(9)	6,425.00
A – 11 — House Reserve	7,600.00	(10)	5,300.00
C – 2 — Legislation	4,200.00		4,200.00
C – 3 — Public Health	2,400.00		2,400.00
C – 4 — Public Relations	6,800.00	(11)	6,300.00
C – 5 — Medical Services	700.00		700.00
C – 6 — Mental Health	—	(12)	1,000.00
D – 1 — President—Presidential Officers	9,850.00	(5)	9,590.00
D – 2 — AMA Delegates	8,630.00	(5)	8,580.00
D – 3 — Woman's Auxiliary	5,675.00	(13)	3,025.00
D – 4 — Medical Education	100.00		100.00
D – 5 — Conference Groups	500.00		500.00
D – 6 — Credentials, Membership Directory	8,500.00	(14)	9,700.00
D – 7 — Emergency Medical Care	325.00		325.00
D – 9 — Archives & History	100.00		100.00
D – 10 — "Project Hope"	—	(15)	6,000.00
D – 11 — Medical Defense & Insurance	300.00		300.00
E – 1 — Board of Trustees	5,200.00	(16)	5,500.00
E – 2 — Contingent	10,000.00		10,000.00
E – 3 — Judicial Council	500.00		500.00
E – 4 — Legal	8,300.00		8,300.00
E – 6 — Medical Student Loan Fund	5,000.00	(17)	13,000.00
Total	$281,339.00		$288,217.00

FOOTNOTES FOR BUDGET

(1)—Decrease due to a change to executive personnel.
(2)—Journal salaries deleted from the budget—authorized by the Board of Trustees.
(3)—Increase due to merited increment, additional staff member, and new job titles for selected personnel in certain job classifications.
(4)—Increase due to additional office service expenses.
(5)—Decrease due to AMA Annual Meeting in Atlantic City.
(6)—Increase due to additional house maintenance expenses.
(7)—Increase due to enlarged annual audit to include the Medical Student Loan Fund and The Pension Plan.
(8)—Increase due to higher salary taxes and one additional employee to the permanent staff.
(9)—Increase due to higher insurance rates and additional staff members covered under existing insurance programs.
(10)—Decrease due to the deletion for one year of the need to purchase IBM typewriters and other capital expenses.
(11)—Decrease due to a deletion of cost not needed in conjunction with the 1967-68 program.
(12)—Establish separate account for Mental Health, in conjunction with its elevation to the status of an administrative council.
(13)—Decrease due to the deletion of the provision made last year for MSNJ co-sponsorship with the auxiliary — a reception honoring Mrs. Yaguda, President of the Woman's Auxiliary to the AMA.
(14)—Increase due to anticipated interim cost between Directory publication.
(15)—New account established — action of the House of Delegates.
(16)—Increase due to higher anticipated costs.
(17)—Increase the contribution to The Medical Student Loan as authorized by the Board of Trustees.

1967-68 Budget

The proposed budget for 1967-68 totals $288,-217.00. It is the opinion of the committee that the budget should adequately provide the necessary funds for the efficient operation of the Society's business during the coming year. It is not to be assumed that all sums budgeted will necessarily be utilized.

As requested by the House of Delegates, the committee is listing explanatory footnotes on accounts showing a marked difference between current and proposed budgets.

Recommendations

1. That the budget for 1967-68 be adopted in the total sum of $288,217.00.

2. That the 1968 assessment be adopted at $40.00 per capita, with no provision for a contribution to AMA-ERF.

3. That the House of Delegates grant continuation for another year of the provision for six (6) Fellowships, each carrying a stipend of $1,000, totalling $6,000.

4. That the House of Delegates vote a special per capita assessment of five dollars ($5.00) to serve as a contribution to the Academy of Medicine of New Jersey for postgraduate education programs of the Academy; and that it apply equally to all dues-paying members.

5. That the special per capita level of contribution be set by the House in addition to and not as part of, the budgetary assessment, and that both be paid at the same time.

Approved (page 403)

Medical Defense and Insurance

Fred A. Mettler, M.D., Chairman, Blairstown
(Reference Committee "D")



During the current year Dr. Daniel F. Featherston, who had been chairman of this Committee since the inception of the current liability coverage program under American Mutual, passed away. The former vice-chairman, Doctor Mettler, was asked to succeed him and Dr. Jerome G. Kaufman was added to the Committee. During the year the Committee met three times.

Professional Liability

On December 18 the Board of Trustees approved the actuarial report submitted by Arthur Stedry Hansen, Consulting Actuary, who had been engaged by the Board to make an independent review of the records of the American Mutual Liability Insurance Company. That report indicated that the conduct of the business by the carrier was in accordance with reasonable practice. In the course of the past few years three features of the professional liability insurance program have required attention. The first of these is the still definitely limited enrollment of our members. Exhibit A is submitted to indicate that this situation is still a matter of concern.

The second problem consists in the fact that the number of claims and suits in counties of territory II — which enjoys lower rates than territory I — now equals or exceeds those in the five counties of territory I. It appears that consideration should be given to determine whether there is any basis for continuing the differential rates currently in existence. Exhibit B shows the distribution of claims and suits by counties.

The third problem is the large number of suits in certain vulnerable specialties, such as orthopedics. The circumstances involved are well-known and are shown in Exhibit C. On the basis of the present condition of the business, the carrier has requested an increase in rates. At the present writing there has not been any opportunity to act upon this, but a meeting of the Committee has been called for April 9. A supplementary report will be issued dealing with this question. A summary of the suits filed up to March 1 of this year appears in Exhibit D.

On June 19 the Board of Trustees directed that Legal Counsel draw up a proper form to be supplied to component societies for the purpose of obtaining their formal agreement to be guided by the advice and assistance of the Board of Trustees of The Medical Society of New Jersey in matters affecting such coverage. This consent form was drawn up by Mr. Backes and has been approved by Mr. Britton.

The Committee on Medical Defense and Insurance approved the form and referred it to the Board, which approved it (March 19, 1967).

Accident and Health Plan

We have just completed the 37th satisfactory year of our accident and health insurance program administered by E. & W. Blanksteen. Our accident and health insurance program provides $1200 monthly benefit of basic coverage with accident benefits payable for five years and sickness benefits payable for two years. Coverage is provided by a $600 basic policy in the National Casualty Company and a $600 basic policy in the Nationwide Mutual Insurance Company. By means of extended coverage policies, the length of time benefits are payable can be extended to lifetime for accident and seven years for sickness. At the present time 3891 of our members participate in the National Casualty Company program and 2952 of our members participate in the Nationwide Mutual Insurance Company program. Many of our members participate in both programs. During 1966, $434,271.43 was paid out to 477 National Casualty Company claimants. During this period of time, $182,825.45 was sent out to 324 claimants under the Nationwide portion of the program. Many of the claimants who received benefits in 1966 had claims which began in earlier years and also a portion of the 1966 claimants are still receiving benefits because they continue to be disabled.

Major Medical Expense Plan

Our Major Medical Expense Policy provides up to $15,000 of benefit, paying 80% of Covered Expenses in excess of a $500 deductible. There are 2637 of our members, plus dependents, participating in this program. In 1966, a record amount of benefits was paid, with $173,988.72 in claim payments sent out during the year. As in the accident and health program, many of these claims had their inception in previous years and also many of the claimants continue to file bills and receive claim benefits on claims begun in 1966 and prior years. The advent of Medicare made it necessary to modify our major medical coverage so as to integrate with Medicare benefits and not duplicate them. This modification was required by the Commissioner of Banking and Insurance. It was important to arrange the integration with Medicare benefits without affecting adversely the benefits payable to spouses who were not of Medicare age and to covered children. This was accomplished and special amendment riders were sent out to all policyholders in March 1967. As a result of this modification, there was a reduction in premium for all members age 60 and over.

Life Insurance—
Nationwide Life Insurance Company

Our life insurance program provides a Five Year Renewable and Convertible Term Policy with a guaranteed conversion on a non-medical basis to permanent life insurance. The program provides up to $100,000 of coverage in units of $10,000 with waiver of premium and double indemnity for accidental death included. At the present time 1,728 of our

members participate in this program with $24,880,000 of insurance currently in force. During 1966 there were 24 death claims with $226,000 in benefits payable to beneficiaries of our members. Of these death claims 11 were impaired risks when the policies were issued and obtained their insurance only because of the qualification of the state society during the initial enrollment. Many of these doctors could not have obtained life insurance elsewhere.

Since the inception of the life insurance program in 1959 there have been 124 death claims with a grand total of $1,181,000 paid out in benefits. Of this number 76 were impaired risks at issuance and many could not have obtained insurance except for the Society's program.

Six Point High-Limit Accident Insurance Plan

Our Six Point High-Limit Accident Insurance Policy with the Nationwide Mutual Insurance Company provides up to $200,000 for accidental death benefit with dismemberment benefit, loss of sight, exposure, disappearance and even a total disability feature. Special spouse coverage is available under this policy at very low cost. Six hundred and sixty-two of our members participate in the program and we are happy to report that there have been no claims under this program during the past year.

Long-Term Disability Insurance

On March 12 the Blanksteen Agency requested the Committee to consider a long-term disability policy of Nationwide Mutual Insurance Company. The Committee voted to recommend that the Trustees approve this proposal, which will be brought before the Board of Trustees at its April meeting.

Recommendations

1) That the American Mutual Liability Insurance Company be continued as the officially designated carrier for the professional liability insurance program.

Approved (page 407)

2) That the E. & W. Blanksteen Agency be continued as the official broker for our accident and health, high-accident limit, and major medical programs.

Approved, as amended, as follows:

That the E. & W. Blanksteen Agency be continued as the official broker for our accident and health, life insurance, high-limit accident, and major medical programs. (page 407)

Approved (page 407)

Exhibit A

County	Doctors Eligible as of 10/1/66	Doctors Insured as of 3/1/67	%
Atlantic	174	45	26
Bergen	808	481	60
Burlington	161	42	26
Camden	407	37	9
Cape May	41	12	29
Cumberland	102	44	43
Essex	1,609	987	61
Gloucester	79	12	15
Hudson	583	317	54
Hunterdon	55	49	89
Mercer	462	179	39
Middlesex	373	284	76
Monmouth	367	228	62
Morris	325	244	75
Ocean	126	57	45
Passaic	619	353	57
Salem	44	5	11
Somerset	126	96	76
Sussex	43	37	86
Union	661	390	59
Warren	39	21	54
Total	7,204	3,920	54

Exhibit B

County	Eligible Doctors as of 3/1/67	Insured as of 3/1/67	Claims Received 1962	1963	1964	1965	1966	5 Yr. Total	Suits Received 1962	1963	1964	1965	1966	5 Yr. Total
Atlantic	174	45	..	..	2	3	4	9	..	..	1	..	2	3
Bergen	808	481	20	26	43	40	31	160	3	4	20	23	22	72
Burlington	161	42	..	..	1	2	2	5	..	..	1	1	1	3
Camden	407	37	1	2	1	1	2	7	..	1	1	..	..	2
Cape May	41	12	..	..	..	..	..	..	..	..	..	..	..	..
Cumberland	102	44	1	..	3	3	2	9	..	..	1	1	1	3

County	Eligible Doctors as of 3/1/67	Insured as of 3/1/67	Claims Received					5 Yr.	Suits Received					5 Yr.
									1962	1963	1964	1965	1966	Total
Essex	1,609	987	55	79	81	73	73	361	16	39	43	40	45	183
Gloucester	79	12	..	..	..	..	..	..	..	..	..	..	..	..
Hudson	583	317	15	12	10	19	18	74	2	5	8	9	11	35
Hunterdon	55	49	..	3	..	..	6	9	..	1	..	1	4	6
Mercer	462	179	6	9	3	8	8	34	1	..	3	..	2	6
Middlesex	373	284	30	17	33	27	27	134	9	9	24	22	14	78
Monmouth	367	228	9	15	25	15	24	88	3	4	21	7	17	52
Morris	325	244	18	18	26	7	23	92	2	1	11	7	5	26
Ocean	126	57	9	9	10	7	9	44	2	2	8	7	2	21
Passaic	619	353	28	33	22	32	28	143	10	17	10	10	22	69
Salem	44	5	..	..	..	..	..	..	..	..	..	..	..	..
Somerset	126	96	9	9	7	11	5	41	2	..	4	11	2	19
Sussex	43	37	1	3	5	2	7	18	..	2	2	1	7	12
Union	661	390	22	27	51	74	39	213	2	13	17	55	32	119
Warren	39	21	..	1	2	1	1	5	..	..	2	..	1	3
Totals	7,204	3,920	224	263	325	325	309	1,446	52	98	177	195	190	712

Exhibit C

Specialty	Insured as of 3/1/67	Claims Received					5 Yr.	Suits Received					5 Yr.
		1962	1963	1964	1965	1966	Total	1962	1963	1964	1965	1966	Total
G.P. No Surgery	311	8	9	3	5	4	29	4	3	2	2	4	15
G.P. Minor Surgery	545	19	14	33	32	23	121	6	7	15	17	15	60
G.P. Major Surgery	346	23	32	19	24	29	127	7	13	12	11	15	58
General Surgery	336	23	20	44	59	45	191	5	11	28	30	27	101
Internal Medicine	489	17	13	30	18	26	104	3	5	11	17	16	52
Cardiology	63	..	3	5	7	1	16	..	1	2	4	1	8
Gastro-Enterology	37	3	2	1	..	1	7	..	1	..	1	1	3
Allergy	31	..	..	2	4	..	6	..	..	1	1	1	3
Pediatrics	263	13	15	13	11	9	61	4	3	6	8	6	27
Obstetrics-Gynecology	263	27	32	39	33	29	180	7	6	25	23	21	82
Anesthesiology	195	29	31	25	33	29	147	3	8	16	14	11	52
Orthopedics	171	20	32	43	36	47	178	6	21	26	24	31	108
Radiology	118	4	8	12	14	13	51	1	1	3	12	9	26
Neuro-Surgery	28	5	2	2	4	7	20	2	2	..	4	5	13
Psychiatry	118	1	3	34	7	3	18	..	..	2	4	..	6
Neuro-Psychiatry	45	..	1	2	2	1	6	..	..	1	1	2	4
E.E.N.T.—No Surgery	21	1	..	..	..	..	1	..	..	..	..	..	..
Opthalmology	131	1	4	5	3	7	20	..	3	4	2	3	12
Otolaryngology	68	5	7	12	8	7	39	2	1	5	6	4	18
Pathology	82	..	5	2	2	2	11	..	2	1	2	1	6
Dermatology	74	6	7	4	3	5	25	..	3	3	1	2	9
Proctology	26	2	..	1	..	..	3	2	..	..	..	..	2
Urology	63	4	8	10	9	5	36	..	6	6	4	6	22
Plastic Surgery	22	3	6	2	3	2	16	..	1	2	3	1	7
All Other Specialties	74	..	..	6	3	4	13	..	..	5	1	4	10
Other Claims	..	10	9	6	5	10	40	..	..	1	3	4	8
Totals	3,920	224	263	325	325	309	1,446	52	98	177	195	190	712

Exhibit D

Suits Filed 11/1/60 to 3/1/67	747
Suits disposed of to 3/1/67	365
Settled	123
Dismissed or withdrawn	141
Summary judgments (by motion)	19
Supreme Court Panel Dismissal	8
Directed verdicts for defendant	29
Jury verdicts for defendant	42
Jury verdicts for plaintiff	3

The 123 suits settled following the recommendations of our county committees would have been settled in most instances whether or not a law suit was filed.

The 141 suits dismissed or withdrawn voluntarily by the plaintiff's attorneys are very important since these attorneys now know that a case will not be settled for a small or nuisance amount if there is no malpractice.

The summary judgments by the Judge and directed verdicts by the Judge at the close

of the plaintiff's case total 48 and present a very encouraging picture.

Of the three jury verdicts for the plaintiff, one was in Hudson County for about the same amount offered in settlement, since it was a case to be settled; another in Union County, and although contrary to the opinion of the Committee, is not appealable in the opinion of our attorney; and the last, also in Union County, is under appeal.

The Supreme Court panels have reviewed twelve cases of which eight were found to have no basis for a claim and were withdrawn by the attorneys. Four were found to have a basis for the claim, one of which was subsequently tried with a jury verdict for the defendant doctor. The remaining three are still defensible in the opinions of our Committees and therefore will not be settled.

Approved (page 407)

Supplemental Report

Since the compilation of the Committee's report to the House, a meeting was held (April 9) in which several important matters were discussed and acted upon. Their significance is such that the Committee calls them to the members' attention at this time.

Professional Liability Insurance

Toward the end of March, the Committee was informed by the American Mutual Liability Insurance Company that their experience with MSNJ's Professional Liability coverage for the first five years has been very bad. Consequently, American Mutual proposed a rate increase which, in most instances, was not equal to their indicated need, as the following indicates:

	Present	*Indicated*	*Proposed*
Class 1			
Physician-no surgery	1.00	1.00	1.00
Class 2			
Physician-minor surgery	1.25	2.02	1.35
Class 3			
Surgeon	2.40	2.11	2.40
Class 4—Surgeon Specialist			
Orthopedist	3.60	14.82	4.50
Other Class 4	3.60	4.71	4.00

The above percentages, using Class 1 as the base, represent the experience for the entire State.

The proposed changes reflect the need to increase substantially Territory II rates, even though they will still be lower than Territory I. The percentage increase for the Class of Practice for Territories I and II follows:

	Territory I	*Territory II*
Class 1	—	17%
Class 2	8%	27%
Class 3	—	17%
Orthopedist	25%	47%
Other Class 4	11%	30%

The above proposed increases will affect the rates for basic limits as follows:

	Territory I *Present*	*Proposed*
Class 1	$102	$102
Class 2	128	138
Class 3	245	245
Orthopedist	367	459
Other Class 4	367	407
	Territory II	
Class 1	$ 75	$ 88
Class 2	94	119
Class 3	180	211
Orthopedist	270	397
Other Class 4	270	351

American Mutual is proposing a 50% reduction in the cost for Partnership Liability which at present represents a surcharge of 10% of the premium for each individual doctor in the partnership and the proposal is to reduce this to a 5% charge.

Because application for the rate increase had to be filed in the office of the Commissioner of Banking and Insurance with an effective date no later than May 1, the Committee recommended — and the Board approved at its April meeting — that the proposed rate increase requested by American Mutual be approved.

The Committee emphasizes that this rate increase is experience-based. The Committee also points out that indications presently are that the state will have eventually one uniform insurance premium rate, perhaps as early as next year.

Approved (page 407)

Long-Term Disability Policy

The Committee considered the Long-Term Disability Policy of the Nationwide Mutual Insurance Company which the Blanksteen Agency is prepared to offer to the membership. The program is designed to integrate with the present programs offered by MSNJ and to appeal, especially, to the younger members of the Society. Since young men provide the backbone of any insurance plan, there is a definite need to attract young physicians to MSNJ's programs by offering plans consistent with their needs.

The details of the program, premiums, and benefits were discussed at length by the Committee and again by the Board of Trustees.

The Board approved the following recommendation of the Committee, subject to the concurrence of the 1967 House of Delegates:

Recommendation

That MSNJ approve the Long-Term Professional Income Protection Plan of Nationwide Mutual Insurance Company as administered by the E. & W. Blanksteen Agency.

Approved (page 407)

Medical Education

Sherman Garrison, M.D., Chairman, Bridgeton
(Reference Committee "D")



That the Committee on Medical Education has had a stimulating and active year is evidenced by the following report.

Resolution #17 1966 House of Delegates

Resolution #17 of the 1966 House of Delegates, urging the expansion of the medical school enrollments and the planning for a third medical school in New Jersey, was referred to the Committee on Medical Education for implementation.

Copies of this resolution were sent to the Dean of Rutgers Medical School and the President of the New Jersey College of Medicine and Dentistry, with a letter stating that the Committee stands ready to work with the medical schools in areas of mutual interest and concern.

Educational Survey

The Committee encouraged a survey by the New Jersey College of Medicine and Dentistry on the effectiveness of courses in the continuing education of physicians by the Department of Psychiatry. The Committee offered to cooperate and assist in this survey and hopes to benefit from the results of it.

In this connection, the Committee has recommended to the Board of Trustees that it be permitted to conduct an educational survey of the membership of MSNJ in the hope of establishing some of the patterns in continuing medical education in relation to the current and immediate needs of physicians. A questionnaire was developed, designed to utilize the experience and advice of the members of this Society in assessing the adequacy of current programs and the areas in which improvements should be made. A draft of the proposed questionnaire has been submitted to the Board of Trustees, and the approval of this project is pending at the time this report is being prepared.

AMA Medical Education Reports

The Board of Trustees directed that the Committee on Medical Education study the two

reports of the AMA Council on Medical Education — *Meeting the Challenge of Family Practice* and *The Graduate Education of Physicians* — and make recommendations to the Board concerning them. The Committee met twice to consider these reports. Invited to one meeting were the Dean of Rutgers Medical School, the President of the New Jersey College of Medicine and Dentistry, and representatives from the Academy of Medicine of New Jersey, and the Academy of General Practice. The specific recommendations of the Committee are being submitted to the Board of Trustees for study and action.

Liaison With Medical Schools

The Bylaws read: "It shall be the duty of this Committee to serve as the contact committee with the medical and dental schools in this state." By meeting with the Dean of Rutgers Medical School and the President of the New Jersey College of Medicine and Dentistry, the Committee has carried out this very important function. It is the feeling of the Committee that an effective liaison has finally been established with the medical schools.

Liaison With Medical Students, Interns, and Residents

The Committee initiated an investigation of the possibility of providing closer relationships among medical students, interns, residents, and organized medicine. In discussing the establishment of liaison between the local chapters of the Student American Medical Association and the area component societies, the Committee decided that if there is to be such liaison the possibility of its establishment should be declared to the chapter and the initiative for such establishment left to them. In considering a closer unity of interns and residents and organized medicine, the Committee requested that the Annual Meeting Committee consider allowing residents to offer papers at the annual meeting. This recommendation is under consideration by the Annual Meeting Committee.

Approved, with the following recommendations:

1. That medical students in New Jersey schools be given exposure to, and contact with, family doctors.

2. That all interested groups of MSNJ communicate, through the Committee on Medical Education, any of its concerns relative to the medical and dental schools. **(page 407)**

Medical Student Loan Fund

Luke A. Mulligan, M.D., Chairman, Leonia
(Reference Committee "B")



In its ten years of operation, the Medical Student Loan Fund has granted a total of $201,244.35 in 208 loans to 127 New Jersey medical students. Seventeen loans have been repaid in full, and twelve loans are being repaid. Eight borrowers are presently making interest payments only.

Student requests for loan benefits are still continuing to be made at a rate that necessitates the acquisition of additional monies for the Fund. In 1964, 1965, and again in 1966, the House of Delegates adopted a $5.00 per capita special assessment, 50% of which served as a contribution to the Medical Student Loan Fund, to be used for loans in the years of the assessments' adoption.

The result of a time-cost study of Fund operations, approved by the Board, shows an average administrative cost to MSNJ of approximately 2% for each $1,000.00 loan granted. Your Committee submits the approximation

at this time because in consequence of the death of Mrs. Madden, who was formerly in charge, and the necessity of the re-assignment of this study work to other staff members, it was not possible to accumulate and evaluate the full details in time for this report. However, the study is now continuing, and in its next report the Committee will present the data upon which decision will be made for charging administrative costs directly to the Fund.

The financial activities of the Fund during the year are included in the report of the Treasurer.

PRESENT LOCATION OF RECIPIENTS OF LOANS

90 Graduates with M.D. Degree:

19 Interns
- 5 in New Jersey
- 14 Out-of-State

37 Residents
- 24 in New Jersey
- 13 Out-of-State

16 Army of the United States
7 United States Navy
11 Private Practice

37 Students Presently in Medical School

24 Seniors
9 Juniors
4 Sophomores

127 Total

DISTRIBUTION OF LOANS

County of Residence	*Medical School*	*Students*	*Loans Granted* 1957-1966	1966-1967 March 31, 1967
Atlantic	Hahnemann	2	$ 2,000.00	
	N. J. Medical	1	1,000.00	
	Pittsburgh	1	2,000.00	
	Temple	1	1,000.00	
	Tufts	1	4,000.00	
Bergen	Boston	1	1,000.00	
	Creighton	1	1,000.00	
	Hahnemann	3	5,000.00	
	N. J. Medical	7	10,000.00**(1)	$ 1,000.00
	N. Y. Medical	1	1,000.00	
	St. Louis	1	1,527.60*	41.40*
	Women's Medical	1	1,000.00	
Burlington	Duke	1	4,000.00	
	Hahnemann	1	1,000.00	
	Jefferson	1	2,000.00**(2)	
Camden	Jefferson	2	2,000.00	
	Michigan	1	2,000.00**(2)	
	N. J. Medical	2	2,750.00*	
	Temple	3	3,500.00	
	Hahnemann	2		2,000.00
Cumberland	Jefferson	1	2,000.00**(2)	
Essex	Albany	1	2,000.00	1,000.00
	Bern	1	2,325.35*	
	Duke	1	2,000.00	
	Hahnemann	2	4,000.00	1,000.00
	Howard	1	300.00	
	N. J. Medical	11	15,650.00	2,500.00
	N. Y. Medical	2	2,000.00**(1)	
	St. Louis	1	500.00	
	Temple	1	1,000.00**(1)	
	Georgetown	1		1,000.00
Gloucester	Hahnemann	1	1,000.00	
	Temple	1	2,000.00**(2)	
	U. of Virginia	1		1,000.00

(* —Includes payment of insurance premiums)
(**—Seventeen (17) loans fully repaid)

County of Residence	*Medical School*	*Students*	*Loans Granted* *1957-1966*	*1966-1967 March 31, 1967*
Hudson	Georgetown	1	1,000.00	
	Harvard	1	1,000.00	
	Howard	1	400.00**(1)	
	N. J. Medical	17	21,500.00	1,000.00
	N. Y. Medical	1	1,000.00	
	Pittsburgh	1	2,000.00	1,000.00
	St. Louis	1	2,000.00	
Mercer	Hahnemann	2	3,000.00**(2)	
	Howard	1	1,000.00**(1)	
	Johns Hopkins	1	1,000.00	
	Meharry	1	250.00	
	Mississippi	1	3,000.00	
	N. J. Medical	3	8,000.00	
	U. of Penna.	1	1,000.00	
	St. Louis	1	700.00**(1)	
Middlesex	Georgetown	1	1,500.00	
	Hahnemann	1	3,000.00	1,000.00
Monmouth	Columbia	1	2,000.00	
	Georgetown	1	1,000.00	
	Jefferson	1	3,000.00	
	Marquette	1	1,000.00	
	N. J. Medical	2	5,000.00	1,000.00
	N. Y. Medical	1	3,000.00	
	Temple	1	2,000.00	
	Up-State N. Y.	1	1,000.00	
Morris	Dartmouth	1	1,000.00	
	Duke	1	1,000.00	
	N. J. Medical	1	3,000.00	
Passaic	Jefferson	1	3,000.00	
	N. Y. Medical	1	1,000.00	
Somerset	Georgetown	1	1,000.00	
	N. Y. Medical	1	2,000.00	
	Temple	1	3,000.00**(1)	
	Western Reserve	1	1,000.00	
Union	Florida	1	1,000.00	
	Hahnemann	1	1,000.00	
	N. J. Medical	11	16,800.00	1,000.00
15 Counties	28 Medical Schools	127	$186,702.95	$14,541.40
Total loans granted 3/31/67				$201,244.35*

Contributions

The Committee is grateful to the many contributors to the Fund, and takes this occasion to acknowledge their support. A list of contributors since the last report follows:

General Fund

The Medical Society of New Jersey, Board of Trustees, STAFF of The Medical Society of New Jersey; County Medical Societies: Burlington, Camden, Cape May, Essex, Gloucester, Hudson, Mercer. State Auxiliary Executive Board; County Auxiliaries: Burlington, Camden, Cape May, Essex, Gloucester, Hudson, Ocean, Passaic, Salem, Warren.

Ocean City Golf Association, Somer's Point, Rose Pappidas Agency, Inc., Dr. and Mrs. Louis Abbamonte, John E. Barber, Dr. and Mrs. Samuel T. Bernson, Dr. and Mrs. A. Guy Campo, Dr. and Mrs. Paul B. Ferrary, Mrs. Lewis C. Fritts, Dr. and Mrs. Floyd Gindhart, Dr. and Mrs. Theodore K. Graham, Dr. and Mrs. John Ianacone, Dr. and Mrs. John F. Kustrup, Mr. and Mrs. Robert Light, Dr. and Mrs. Samuel Lloyd, Mrs. George L. McCarthy, Dr. and Mrs. Luke A. Mulligan, Dr. and Mrs. Irving Newman, Dr. and Mrs. Paul H. Pettit, Dr. and Mrs. Paul Rauschenbach, Dr. and Mrs. Carl Records, Dr. and Mrs. Thomas Sanfacon, Dr. and Mrs. Jocob R. Schwartz, Dr. and Mrs. John Scillieri, Dr. Paul R. Sparks, Mrs. H. Roy Van Ness, Lorena G. Van Ness.

In Memory Of

Scipio H. Africano, M.D., Anthony J. Alexander, Nicholas Anerina, Mrs. Maude Backes, Peter Berkout, Vincent P. Butler, M.D., Mrs. Richard Cudahy, Alice Davis, Irvin E. Deibert, M.D., Edward Devenney, Paul F. Drake, Daniel F. Featherston, M.D., Max D. Fried, Augustin Gallardo, Ernest S. Graulich, Luther M. Hartman, Hans Hilgert, Mrs. Harry V. Hubbard, father of Mrs. Jacob Horowitz, Alfred Hoffman, M.D., J. Thornley Hughes, Howard Hughes, Mrs. Janet Hughes, Nathan Jacks, Edmond L. Kenyon, William Koslow, M.D., Selma Levin, Mrs. E. Lovett, Mary Lyle, Edith L. Madden, Joseph Marks, H. Richard Mayer, M.D., William Mayer, M.D., Salavatore L. Meshon, M.D., John F. Moriarty, M.D., Charles Murn, M.D., Martin Newstreet, Louis Papidas, John Paulson, Mrs. Christian F. Rasmussen, Austin M. Schultz, Jacob Segan, M.D., John B. Sill, M.D., Mrs William R. Stevenson, Benjamin A. Treiber, M.D., J. Wallace, Mrs. T. G. Wandall, Mrs. Charles Zimmerman.

In Honor Of

Mrs. Ethel Bernson, Mrs. George Craik, Mrs. Don A. Epler, Mrs. Lewis C. Fritts, Mrs. Jesse T. Glazier, Passaic Auxiliary Committee Chairmen, State Auxiliary Executive Board, Mrs. David Zuckerman.

Bicentennial Commemorative Contributions

Although in the 1966 report we presented a list of such Bicentennial Commemorative Contributions as then had been made, this year, for the information of the House and the integrity of record, we are supplying a full listing of all such contributions:

1) The names of donors of $500.00 or more are being inscribed on a bronze plaque to reside permanently in the Executive Offices of The Medical Society of New Jersey reading "Bicentennial Donors to the Medical Student Loan Fund of The Medical Society of New Jersey." The names are:

Becton, Dickinson & Co.; E. & W. Blanksteen Agency, Inc., Camden County Woman's Auxiliary; Camden County Medical Society; Chalfonte-Haddon Hall; Ciba Pharmaceuticals; Cumberland County Woman's Auxiliary; Cumberland County Medical Society, Essex County Woman's Auxiliary; Geigy Chemical Corp.; Hoffman-LaRoche; Hudson County Medical Society; Johnson & Johnson; Mercer County Woman's Auxiliary; Middlesex County Woman's Auxiliary; Dr. & Mrs. Luke A. Mulligan; Ocean County Woman's Auxiliary; Organon, Inc.; Salem County Medical Society and Woman's Auxiliary; Wallace Laboratories; Warner-Chilcott Laboratories.

2) The names of those giving $100.00 or more, but less than $500.00, are being recorded on an additional special laminated plaque. The names are:

Atlantic County Woman's Auxiliary; Cape May County Medical Society; Gloucester County Medical Society; Knoll Pharmaceuticals; Mercer County Component Medical Society; Morris County Auxiliary; Passaic County Women's Auxiliary; A. H. Robins Co., Inc.; White Laboratories.

The plaques are being prepared and will be installed, with appropriate ceremonies, in the Executive Offices.

Recommendations

1) That the House of Delegates appropriate monies to the Fund to be used for loans in 1967-68;

2) That the membership be urged to send contributions to the Fund; and

3) That the Woman's Auxiliary to The Medical Society of New Jersey again be requested to make the Fund its number one project during 1967-68.

Approved, with the following suggestion:

That measures be continued by the Medical Student Loan Fund to see that recipients of loans will intern in New Jersey hospitals. (page 403)

Not Too Late To Stop Smoking

For 30 years the Public Affairs Committee has been issuing well-written brochures on major topics of general interest to the public. Pamphlet Number 386—the 30th anniversary publication—is entitled *It's Not Too Late to Stop Smoking.* Without preaching, it summarizes the defenses offered for continued cigarette smoking, the case against smoking, and some practical pointers on how to quit. The pamphlet is available at 25¢ from the Public Affairs Committee at 381 Park Avenue South, New York City 10016.

Publication

George B. Sharbaugh, M.D., Chairman, Trenton

(Reference Committee "B")



Your Committee continued to work with the problems of *The Journal* with increasing success. With the appointment of an advertising manager, the income of *The Journal* substantially rose during 1966. The detailed financial statement is shown in the annual report of the Treasurer. This statement reflects an increase in advertising revenue, and a corresponding reduction again this year in *Journal* deficit. A 15 per cent rate increase in display advertising became effective on July 1, 1966. The rate increase partly accounts for the increase in revenues. The number of pages of advertising during the calendar year 1966 jumped to 660 pages, from the previous year's 485. Multi-color inserts were widely used, and averaged almost twelve pages per month. The first three months in 1967 (not reflected in the tabular comparison) averaged 75 pages of advertising per month.

In the nine months period from June 1, 1966 to March 1, 1967, *The Journal* received $42,475 in advertising income and $3,477 in other income, for a total of $45,952. Only $758 was deducted for discounts, leaving a net income of $45,194. Our expenses totaled $58,899, representing a deficit of $13,705. Thus, *The Journal,* in effect, cost the members under $2 a year, which we would consider a bargain in any language.

It had been suggested that we could sell even more advertising at high rates if we interspersed advertisements among the scientific, editorial, or organizational content. However, your Committee did not wish to do this, and the Board of Trustees concurred in the decision to keep advertising and scientific sections separated.

The Bicentennial cover was discontinued at the close of the Bicentennial Year (December, 1966 issue). A new cover, approved by the Board of Trustees, was first used in January, 1967.

Theresa E. Goeke resigned as Assistant Editor, effective February 1, 1967. Marjorie D. Treptow became Editorial Secretary in September, 1966, and our Advertising Manager, Joseph W. Cookson, assumed his duties October 1, 1966.

The Academy of Medicine now supplies us with a calendar of "Meetings of Medical Interest." This feature not only provides our readers with material for their diaries, it also reduces the likelihood of conflicts of dates when medical societies plan their meetings.

Because of rising costs and limited resources, necessitating curtailment of activities, The New Jersey Tuberculosis and Health Association has discontinued (with the publication of the April, 1967 issue) sponsoring the printing of "Abstracts On Tuberculosis And Other Respiratory Diseases," for many years a regular feature of our *Journal.*

Tabular comparison for last four years:

	1963	*1964*	*1965*	*1966*
Book Reviews	21	34	39	21
Editorials	28	24	25	28
Letters and Announcements	15	11	16	17
Original Articles	279	255	237	207
*State Activities	209	206	275	305
Total of text material	558	530	592	578
Advertising	620	482	485	660
Grand Total of Pages	1178	1012	1077	1238
Ratio: advertising/text	53%	48%	45%	53%

*Includes obituaries.

Please note the four-year tabular comparison listed above. The rise in the advertising ratio from 45 to 53 per cent in one year is not only

a source of increased revenue, but is also evidence of the fact that *The Journal* is really read. (Advertisers find out.) Because we had had a deficit previously, we reduced the total number of pages in the "original articles" from 237 to 207. While we thus had lessened quantity, it made it possible for us to be more selective. The most conspicuous feature of the table is the jump from 485 to 660 pages of advertising.

Approved (page 403)

Woman's Auxiliary Advisory

George O. Rowohlt, M.D., Chairman, Dumont

(Reference Committee "H")



The official programs and projects for 1966-1967 were submitted and approved by the Board of Trustees. The work of the Auxiliary was so efficiently planned and consummated that there was no need for a formal meeting of this Committee.

Among the many projects of the Auxiliary this year, those of outstanding interest were:

1) The sale of the bicentennial mementos (plates and plaques project) to increase the Medical Student Loan Fund. The Medical Student Loan Fund of The Medical Society of New Jersey was given number one priority in the program.

2) Assisting at health forums, health fairs, and in mental health programs.

3) One county was responsible for making it possible to distribute kits on narcotic addiction prevention to the libraries of all grade and junior high schools in its area. This county is also helping to establish a clinic which will be manned by county doctors assisted by auxiliary members. The making of a new film to replace "The Decision," an outdated film on narcotic addiction prevention, is also being actively sponsored by this county.

4) International health activities resulted in a large collection of drug samples, medical instruments, bandages, etc. for distribution in Asia, Africa, and South America. By the diligent efforts of one county and the enlisting of McGuire Air Force Base cooperation, the Auxiliary was able to send supplies directly to the city clinics in Lima, Peru. This was noteworthy because the original shipping contact was lost, and in Lima they were desperate for supplies.

5) Many counties held allied health careers' programs for high school students.

6) Safety programs were emphasized in many counties of the state.

At the time of the report, the Auxiliary is requesting permission to support MSNJ and its component societies in a proposed program to combat venereal disease, which has been increasing at an alarming rate in New Jersey and throughout the nation.

The Committee wishes especially to commend one member of the Auxiliary, Mrs. Asher Yaguda, for her outstanding achievements as President of the Woman's Auxiliary to the American Medical Association.

It is with pleasure that the Committee again expresses appreciation for the Auxiliary's continued support of MSNJ activities and its cooperative efforts to protect the health and welfare of the people of New Jersey.

Approved (page 417)

Revision of Constitution and Bylaws

Louis F. Albright, M.D., Chairman, Spring Lake
(Reference Committee on Constitution and Bylaws)



The Committee had several proposals before it this year in accordance with its function and scope — outlined in the Bylaws (Chapter IX, Section 17, b.):

The Committee shall be responsible for preparing and/or evaluating proposed revisions to the Constitution and/or Bylaws, and for properly submitting them to the House of Delegates.

Because of the number of proposals submitted and the complexity of the items covered, the Committee has dealt with each one separately and in detail. They are here presented in the order in which sequentially they pertain to the Constitution and Bylaws. Members of the House are urged to study this report carefully in advance of the annual meeting and to become familiar with all aspects of the items dealt with.

Council on Mental Health

The Committee considered the following item, referred by the Board of Trustees for proper amendment to the appropriate section of the Constitution and/or Bylaws, and recommends to the House the actions indicated:

Mandate of the 1966 House of Delegates that the Special Committee on Mental Health be elevated to the status of an administrative council.

Preparation: The Committee unanimously adopted the accompanying format (Exhibit #1), for submission to the 1967 House.

Evaluation: The Committee unanimously agreed that the proposed amendment would effectuate the mandate of the 1966 House of Delegates, as outlined in the recommendation of the Committee on Mental Health.

Approved (page 418)

Reapportionment of Representation

The Committee considered the following item, referred by the Board of Trustees for proper amendment to the appropriate section of the Constitution and/or Bylaws, and recommends to the House the actions indicated.

Recommendations from the Ad Hoc Study Committee appointed by the Board:

a) That the office of "eleventh trustee" be discontinued, upon expiration of the term of the incumbent.

b) That each judicial district be represented by two trustees for a membership up to 1000 and that each judicial district be entitled to one additional trustee for each additional 1,000 members or major fraction thereof.

Preparation: The Committee adopted the accompanying format (Exhibit #2), for submission to the 1967 House of Delegates. The Committee reaffirmed that "major fraction thereof" (referred to in the proposed amendment) shall mean 501 or more.

Evaluation: The Committee had the advantage of studying the minutes of the meetings of the Ad Hoc Study Committee on Constitution and Bylaws, appointed by the Board of Trustees to carry out the directive of the 1966 House of Delegates "that a special committee study the recommended revision to the Constitution and Bylaws concerning the Procedure of Election, Chapter 5, for report to the 1967 House."

The Committee concurred in the conclusions and recommendations of the Ad Hoc Study Committee in arriving at its decision.

Approved, with the following recommendation:

That the entire matter of representation on the Nominating Committee be returned to—and studied in depth by—the Committee on Revision of Constitution and Bylaws, for subsequent report to the House. (page 419)

Amendments from Component Societies

Article XII and Chapter XII of the MSNJ Constitution and Bylaws require that all proposed amendments be transmitted by the Secretary to the Committee on Constitution and Bylaws not later than February 15; that they be studied by the Committee; and that the Committee report on them at the first session of the House of Delegates. In accordance with these provisions the Committee received

from the Secretary the following proposals for consideration by the 1967 House of Delegates and took the actions indicated.

Abolition of Eleventh Trustee

The Morris County Medical Society submitted a resolution to abolish the office of "eleventh trustee" (Constitution — Article VI . . . Board of Trustees).

Preparation: The Committee adopted the accompanying format (Exhibit #3), to effect the intent of the resolution.

Evaluation: The Committee concurred in the recommendation of the Ad Hoc Study Committee — approved by the Board of Trustees — that the office of "eleventh trustee" be abolished.

No action (page 419)

Reapportionment of Nominating Committee

The Essex County Medical Society submitted a proposal to reapportion the voting strength in the Nominating Committee in favor of more populous counties (Bylaws — Chapter V . . . Procedure of Election, Section 2).

Preparation: The Committee unanimously agreed that the format submitted (Exhibit #5) was proper for transmittal to the 1967 House of Delegates.

Evaluation: The Committee pointed out that this proposed amendment is exactly the same as one submitted last year by the Union County Medical Society. The 1966 House of Delegates, in considering the identical amendment last year, approved the following report and recommendations of the reference committee:

The recommended revision of the Constitution and Bylaws as proposed concerning Chapter V — Procedure of Election — as presented to the first meeting of the [1966] House of Delegates was read and discussed by the Committee and members attending the [1966] Reference Committee on Constitution and Bylaws. Such discussion included remarks concerning proper representation of individual counties and proposed changing of representation of individual counties according to size. The discussion included remarks for and against such a change. The proponents of a change agreed that further study of the problem was justified.

The [1966] reference committee recommends (and the [1966] House approved) that the subject be referred to the Board of Trustees for further study by a committee which would include members of the permanent Committee on Revision of Constitution and Bylaws. The members of this committee realized the depth of this problem, but believe that the conclusions of the study can be completed and recommendations be made at the next meeting of the House of Delegates at the 1967 Annual Meeting.

The Committee reviewed the relevant portion of the minutes of meetings of the Ad Hoc Study Committee (created by the Board of Trustees to carry out the 1966 House directive) and concurred in the conclusions and recommendations, which follow:

It was the unanimous opinion of those present that a reapportionment of voting strength within the Nominating Committee, as proposed in the (1966) Union County Amendment, is not desirable because the populous counties — in consequence of their greater number of delegates — can proportionately influence the election itself and thus have a strong impact upon the choice of elected officials of the Society. To modify the present voting balance within the Nominating Committee might lead to discouragement of nominees from small counties and result in nominations from the floor that would unnecessarily lengthen the election sessions of the House of Delegates.

The members of the Committee, therefore, unanimously voted *to recommend* that no change be made in the apportionment of voting strength within the Nominating Committee.

Not adopted (page 419)

Recommendation of reference committee approved:

That the entire matter of reapportionment of representation on the Nominating Committee be returned to—and studied in depth by—the Committee on Revision of Constitution and Bylaws. (page 419)

Emeritus Membership

The Committee has had under advisement for some time the following referral from the 1965 House of Delegates:

There is a definite possibility that an emeritus member might want to return to practice at some time in the future or that an emeritus member might decide to practice in another state at some time in the future. It is unclear as to how the situation would be met. The Committee *recommends* that the Committee on Revision of Constitution and Bylaws review the possibilities of these eventualities and possibly present an amendment in the future.

The Committee noted that, subsequent to this referral, the Board of Trustees (July 1965) adopted the following policy decision:

That an emeritus member be permitted to reinstate his active membership upon payment of his dues and a statement in writing requesting such reinstatement.

The Committee was unanmious in its agreement — concurred in by Legal Counsel — that the policy statement of the Board of Trustees takes care of the matter satisfactorily and eliminates the necessity of any further action.

Approved (page 418)

Associate Membership

The Committee likewise has had under advisement a referral from the Board of Trustees dealing with the probationary period of associate membership. It was the opinion of the Board that (1) an associate membership longer than a two-year period would be improper; and (2) an associate member should be dropped at the end of the probationary period if he does not fulfill his obligation. The matter was referred to the Committee on Revision of Constitution and Bylaws for study and possible amendment.

It was the opinion of the Committee — concurred in by Legal Counsel — that the county medical societies are handling this situation satisfactorily. The Committee unanimously agreed that no further action is necessary or desirable.

Approved (page 418)

Exhibit #1

Bylaws

Chapter IX — Administrative Councils and Committees
Section 4 — Administrative Councils and Committees

Current	*Proposed*
(a) The Administrative Councils shall be:	(a) The Administrative Councils shall be:
Council on Legislation	Council on Legislation
Council on Medical Services	Council on Medical Services
Council on Public Health	*Council on Mental Health*
Council on Public Relations	Council on Public Health
	Council on Public Relations

Chapter XI — Administrative Councils and Committees

Section 7 — Council on Mental Health

(a) *The Council on Mental Health shall consist of twelve (12) members, six (6) of whom shall be elected by the House of Delegates, and six (6) appointed by the President. Their terms shall be for three (3) years, so arranged that at each annual meeting the terms of two (2) elected and two (2) appointed members expire. There shall be at least one (1) elected and one (1) appointed member from each judicial district. Candidates for appointment may be suggested to the President by the component societies in the district in which a vacancy exists.*

(b) *The function of the Council on Mental Health shall be to study and evaluate all matters of interest to this Society in the fields of alcoholism, drug addiction, mental retardation, mental illness of children and adolescents, epilepsy, neurological disorders, and psychiatric disorders. The Council shall report findings and recommendations to the Board of Trustees relative to official policies and positions of this Society in the area of assigned concern.*

(c) *The Immediate Past-President shall be a member, ex-officio, of the Council on Mental Health.*

Section 7—Council on Public Health	Section *8*—Council on Public Health
Section 8—Council on Public Relations	Section *9*—Council on Public Relations
Section 9—Committee on Annual Meeting	Section *10*—Committee on Annual Meeting
Section 10—Committee on Credentials	Section *11*—Committee on Credentials
Section 11—Committee on Finance and Budget	Section *12*—Committee on Finance and Budget
Section 12—Committee on Honorary Membership	Section *13*—Committee on Honorary Membership
Section 13—Committee on Medical Defense and Insurance	Section *14*—Committee on Medical Defense and Insurance
Section 14—Committee on Medical Education	Section *15*—Committee on Medical Education
Section 15—Committee on Medical Student Loan Fund	Section *16*—Committee on Medical Student Loan Fund
Section 16—Committee on Publication	Section *17*—Committee on Publication
Section 17—Committee on Revision of Constitution and Bylaws	Section *18*—Committee on Revision of Constitution and Bylaws

Section 18—Advisory Committee to the Woman's Auxiliary	Section *19*—Advisory Committee to the Woman's Auxiliary
Section 19—Special Committees	Section *20*—Special Committees
Section 20—Reference Committees	Section *21*—Reference Committees

Adopted (page 418)

Exhibit #2

Constitution

Article VI — Board of Trustees

Current	*Proposed*
The Board of Trustees shall be the executive Body, and shall be composed of the Immediate Past-President, President, President-Elect, two (2) Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), and eleven (11) members—at least two (2) from each judicial district, and who shall each be elected for a term of three (3) years, such term to commence upon expiration of the term of the then incumbent.	The Board of Trustees shall be the executive body, and shall be composed of the Immediate Past-President, President, President-Elect, two (2) Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), and *elected Trustees* — at least two (2) from each judicial district *for a membership up to one thousand (1,000); each judicial district shall be entitled to one (1) additional Trustee for each additional one thousand (1,000) members, or major fraction thereof, computed as of December 31. The term of elected Trustees* shall be for three (3) years, such term to commence upon expiration of the term of the then incumbent.

Approved (page 419)

ACTIVE MEMBERSHIP OF MSNJ BY DISTRICT

District	County	Members
FIRST	Warren	39
	Morris	316
	Essex	1,518
	Union	622
		2,495
SECOND	Sussex	42
	Passaic	596
	Bergen	751
	Hudson	564
		1,953
THIRD	Hunterdon	56
	Somerset	111
	Middlesex	354
	Mercer	465
		986
FOURTH	Monmouth	345
	Ocean	122
	Burlington	156
	Camden	396
		1,019
FIFTH	Gloucester	78
	Salem	43
	Cumberland	97
	Atlantic	167
	Cape May	33
		418

The foregoing information is supplied for reference purposes only.

ACTIVE MEMBERSHIP OF MSNJ BY DISTRICT

At December 31, 1966

County	Members
Atlantic	167
Bergen	751
Burlington	156
Camden	396
Cape May	33
Cumberland	97
Essex	1,518
Gloucester	78
Hudson	564
Hunterdon	56
Mercer	465
Middlesex	354
Monmouth	345
Morris	316
Ocean	122
Passaic	596
Salem	43
Somerset	111
Sussex	42
Union	622
Warren	39
Total	6,871

Exhibit #3

Constitution

Article VI — Board of Trustees

Whereas, the "11th trustee" does not represent any district on the Board of Trustees of The Medical Society of New Jersey; and

Whereas, the position of the "the trustee" gives inappropriate consideration to the members of his district; and

Whereas, the "11th trustee" is not necessary for "tie-breaking" since there are seven officers included on the Board of Trustees; and

Whereas, the regulations for succession to the position of the "11th trustee" have been vague and confusing in the past; therefore be it

RESOLVED, that the Constitution and Bylaws of The Medical Society of New Jersey be amended so as to eliminate the office of "11th trustee."

Current	*Proposed*
The Board of Trustees shall be the executive body, and shall be com-	The Board of Trustees shall be the executive body, and shall be com-

posed of the Immediate Past-President, President, President-Elect, two (2) Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), and eleven (11) members—at least two (2) from each juidical district, and who shall each be elected for a term of three (3) years, such term to commence upon expiration of the term of the then incumbent.	posed of the Immediate Past-President, President, President-Elect, two (2) Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), and *two (2) members* from each judicial district, who shall be elected for a term of three (3) years, such term to commence upon expiration of the term of the then incumbent.
Any member may be elected a Trustee for a maximum of three (3) full terms.	Same
At the first election of Officers following the adoption of this Constitution, three (3) members shall be elected for a period of one (1) year; four (4) members for a period of two (2) years; four (4) members for a period of three (3) years; and, as the terms of these elected Trustees expire, new elections shall be for periods of three (3) years each.	Same

No Action (page 419)

Exhibit #5

Bylaws

Chapter V — Procedure of Election

Section 2 — Procedure of Nomination

Current	*Proposed*
(a) The chairman of the Nominating Committee shall be the Immediate Past-President of this Society, or, in the event he is unable or unwilling to serve, a member designated by the Fellows. The committee shall elect one (1) of its own members to serve as secretary, who shall call the roll of accredited members of the committee as certified by the Secretary of this Society.	Same
The chairman shall read to the committee this section of the Bylaws (Chapter V, Section 2) before proceeding to any other business.	Same
(b) The Secretary of this Society shall furnish to the committee such information as is necessary for the proper conduct of its business, including a list of all offices to be filled.	Same
(c) All nominations shall be made by individual alphabetical roll call of the counties, the first county to be called to be determined by lot. This order having been established at any annual meeting shall be the order for that meeting.	Same
The representative of each county, when his county is called, may nominate a candidate, second a nomination, or waive his privilege in favor of another county. The representative of the county so favored may then nominate a candidate, or second a nomination, after which the roll call shall be continued from the point where it was interrupted by the waiver.	Same
	The representative of each county shall cast one (1) vote for each five hundred (500) members of the component society, or major fraction thereof. Each component society shall have at least one (1) vote.
The chairman shall have only the right to vote in case of a tie.	Same
The secretary shall announce the result upon completion of each roll call. If the tabulation of any roll call be challenged by any member of the committee, the roll shall be called again. A majority vote of the members present shall nominate. In the event that no candidate has received a majority of the votes cast, the name of the candidate receiving the least number of votes shall be dropped. The call of the roll shall be repeated until a nomination is made.	Same
(d) Nothing in this section is to be construed as preventing the nomination and election of Fellows to the Board of Trustees.	Same
(e) The election of Trustees shall conform to the provisions of Article VI of the Constitution.	Same

No Action (page 419)

Administrative Councils

Legislation

Jesse McCall, M.D., Chairman, Newton
(Reference Committee "E")



It is never possible for the Council on Legislation to present an all-inclusive report for the administrative year. As an administrative council of the Society, it operates within the administrative year of MSNJ. By virtue of its function, however, it must follow the Legislature on the basis of a calendar year. As a result, some of the items in this report were dealt with by the 1966 Legislature, while others are still under consideration of the 1967 session. For this reason, this report deals with them separately.

At its first meeting for the calendar year, the Council was called upon to deal with as many bills as were considered by it during the entire past calendar year. All bills introduced at state level have been reviewed by the Legislative Analyst. Those of medical interest have been carefully analyzed by him and discussed before the Council. Many of the measures, as indicated, are repeaters from previous years.

The Council had occasion this year to re-emphasize the importance of specialty societies' and component societies' not acting independently of MSNJ on legislative matters. Action taken at state level is the result of much study, authoritative advice, and thorough evaluation. Specialty societies and component societies should acquaint themselves with the Society's positions before taking positions in their own name.

1966 Legislative Summary

The 1966 (190th) session of the New Jersey Legislature adjourned *sine die* at noon on January 10, 1967. During that session, a total of approximately 1,584 pieces of legislation was introduced — an increase over the preceding year in excess of 200. The Council gave detailed study to 111 measures as relevant to the Society's interest and concern. Of this total (1) twenty bills approved by MSNJ became law; (2) two bills disapproved by MSNJ became law; (3) three bills actively opposed by the Society became law; (4) seven bills on which the Society had a position of "no action" were signed into law. A detailed summary report of all bills considered by the Council during 1966 — including those signed into law — was regularly reported in *The Journal* and the *Membership News Letter.*

1967 State Legislation

In the afternoon of January 10, the 191st (1967) session of the New Jersey State Legislature was opened. Since that time, the Council has considered the bills listed in this report. It is obvious that a record number of bills have thus far been introduced in both Houses.

It is reported that the Legislature is aiming for adjournment in mid-May until the Fall. With an augmented Legislature to be elected next November, most of the incumbent law makers are seeking re-election. It is reported that this is the cause of the record number of bills introduced so early in the session. Elected next November will be 40 State Senators instead of the present 29 and 80 Assemblymen instead of the present 60.

The Society's official position on all current state legislation is regularly called to the attention of component societies through the minutes of meetings of the Board of Trustees. These positions are likewise called to the attention of legislators, cooperating agencies, county keymen, and county secretaries and executive secretaries by means of official legislative bulletins. The members are regularly kept informed through the *Membership News Letter* and *The Journal.*

The Board of Trustees has adopted the positions indicated on the bills listed below. The Society has adopted the following regular range of official positions concerning proposed legislation:

Active Support . . . all-out support for the measure

Active Opposition . . . all-out opposition to the measure

Approval . . . commended as satisfactory, but not actively supported

Disapproval . . . rejected as unsatisfactory, but not actively opposed

No Action . . . considered, but not regarded as significant or relevant to the proper interests of MSNJ

(Positions of active opposition and disapproval are always accompanied by a statement of reasons.)

All measures thus marked (*) are identical with bills of last year — or preceding years — whose official MSNJ positions were identical.

S-15 —To require all milk tops to have the days of
A-157—the week the milk was pasteurized fully spelled out or abbreviated in no less than three first letters. *NO ACTION*

S-19 —To create the Division of Postmortem Examiners in the State Department of Health. *ACTION DEFERRED* . . . pending introduction of an Administration-sponsored bill dealing with the same subject.

S-29 —To exempt from the "Sales and Use Tax Act" all medicines and physical corrective devices, soaps, detergents, and household products. *APPROVED*

S-30 —To exempt from the "Sales and Use Tax Act" artificial devices designed to alleviate physical incapacity. *APPROVED*

*S-39 —To provide for increases in maximum benefits
*A-1 —for permanent partial disabilities; increases in funeral allowances; free choice of physician; a Board of Workmen's Compensation Appeals; and other changes. *NO ACTION*

S-55 —To exempt from the "Sales and Use Tax Act" sales of over-the-counter drugs and certain physical corrective devices. *APPROVED*

S-57 —To provide that Sections 1 and 2 of Chapter 170, Title 2A (concerning drugs), shall not apply to licensed medical practitioners acting in the regular course of their business or profession. *ACTION DEFERRED* . . . pending further study and investigation.

*S-73 —To prohibit the discharge of pollutant matter or materials into inland tidal waters and to regulate the operation of toilet facilities in vessels in said waters. *APPROVED*

*S-79 —To eliminate the need for a physician's certificate in connection with an absentee ballot for temporary disability. *DISAPPROVED,* because it would encourage self-diagnosis.

*S-81 —To forbid hypnotizing as a form of entertainment. *APPROVED*

S-84 —To provide that municipalities may promul-
A-227—gate air pollution ordinances and regulations when necessary for their localities, which shall not be in conflict with — but may be more restrictive than — state law. *NO ACTION*

*S-123—To provide for education of students in the
*A-280—professions of medicine and dentistry. *APPROVED*

*S-146—To provide for the disposition of human remains and parts thereof by written instrument signed by the donor and two witnesses. *APPROVED*

S-148—To prohibit littering of waterways and adjacent shores and beaches and to regulate marine toilets. *APPROVED*

S-150—To exempt from the "Sales and Use Tax Act" any services rendered with respect to personal property exempt from taxation; over-the-counter drugs; artificial apppliances which alleviate physical incapacity; soaps, detergents, household paper, and plastic products; pet foods; sales of the American flag; and to consider non-profit volunteer fire companies, first aid, ambulance rescue, and emergency squads as exempt organizations. *APPROVED*

S-154—To provide for reimbursement for any optometric service under health and sickness insurance policies whether said service is performed by a physician or a duly licensed optometrist. *DISAPPROVED* as unnecessary, since the optometrist is already entitled to payment for services rendered under any insurance policy which provides for optometric services.

S-155—To provide that benefits of medical service corporations shall not be denied eligible individuals for eligible services performed by a duly licensed optometrist. *ACTIVE OPPOSITION* (post-facto 1.26.67), because the services which optometrists are licensed to provide are not among the services covered by Medical Service Corporations.

S-156—To provide for reimbursement for any optometric service under group accident, group health, and group accident and health insurance policies whether said service is performed by a physician or duly licensed optometrist. *DISAPPROVED* as unnecessary, since the optometrist is already entitled to payment for services rendered under any insurance policy which provides for optometric services.

*S-157—To provide for the licensing and registration of electrologists by the Board of Medical Examiners. *APPROVED*

S-159—To exempt from the "Sales and Use Tax Act"
A-407—sales and admission charges made in connection with fund raising events conducted by non-profit associations or corporations where proceeds are used for charitable purposes and to consider as an exempt organization one which conducts affairs for the purpose of raising funds for its authorized purposes. *APPROVED*

S-160—To exempt from property taxation any facility used primarily for preventing or abating water pollution. *APPROVED*

S-180—To increase the penalty for violation of the Air Pollution Control Act to $25,000, each day a separate offense; and to rebate up to 90% of such penalty where the violation has been eliminated within one year. *NO ACTION*

*S-194—To require every board of education to employ an optometrist or ophthalmologist. *ACTIVE OPPOSITION,* because the school physician already has the obligation to screen for physical defects, including impairment of vision. The addition of an optometrist or ophthalmologist would, in consequence, be an unjustifiable and expensive redundancy.

*S-209—To include under the scope of laws dealing with the practice of optometry any who offer and market for sale at retail to the general public spectacles or eyeglasses containing other than plano lenses. *DISAPPROVED* as unnecessary, because the vending of such glasses is not proper or exclusive to the practice of optometry, whose fundamental function (under law) is to examine for defects of vision and to prescribe corrective lens. This legislation would deny to the public access to low-cost eyeglasses of simple magnification, and thus is restrictive of free choice and is discriminatory.

*S-210—To include in the practice of optometry any person who prescribes or dispenses to the general public spectacles or eyeglasses containing other than plano lenses. *DISAPPROVED* as unnecessary, because the vending of such glasses is not proper or exclusive to the practice of optometry, whose fundamental function (under law) is to examine for defects of vision and to prescribe corrective lens. This legislation would deny to the public access to low-cost eyeglasses of simple magnification and thus is restrictive of free choice and is discriminatory.

*S-213—To provide that any person who practices ophthalmic dispensing in violation of the act governing regulation of the practice shall be liable to a penalty of not more than $200. *DISAPPROVED,* because it would deny to the public access to low-cost eyeglasses of simple magnification and thus is restrictive of free choice and is discriminatory.

*S-214—To direct the Department of Institutions and
*A-455—Agencies to determine a program and plan for medical assistance for the needy in accordance with social security programs providing old age assistance, aid to the blind, aid to dependent children, and aid to the disabled. *APPROVED*

*S-215—To correct several technical errors in the
*A-166—mental retardation act. *APPROVED*

S-251—To permit a municipality to purchase, take by gift or through condemnation, any interest in real property for sale or conveyance to a state-operated college of medicine or college of medicine or dentistry and to establish a procedure therefore. *NO ACTION*

S-253—To provide for the construction, administration, and supervision of a Neuropsychiatric Institute in the Department of Institutions and Agencies by Rutgers, The State University. *NO ACTION*

*S-271—To require every district and regional board of education to appoint an advisory committee on narcotics to aid and advise the board of measures needed to prevent trafficking in, improper use of, and addiction to narrcotics within the high school. *NO ACTION*

S-288—To provide for state inspection of motorcycles and to authorize the Director of Motor Vehicles to prescribe certain safety equipment. *APPROVED*

S-292—To authorize local units, including a city, to acquire land for use of a college of the New Jersey College of Medicine and Dentistry; to incur indebtedness and to issue negotiable bonds for such purposes. *NO ACTION*

S-307—To permit the Board of Medical Examiners to grant a license for the practice of medicine and surgery without further examination where an applicant shows he has been examined and licensed in a foreign country. *DISAPPROVED,* because it would circumvent the orderly and dependable procedure for licensing of physicians adopted by the State of New Jersey as a means of protecting the public against unqualified practitioners. It would impose upon the State Board of Medical Examiners the almost impossible responsibility of ascertaining the standards of licensure applied in all foreign countries, and of deciding whether those standards may be accepted as equivalent to those which New Jersey imposes, or to those of other states whose licensees New Jersey accepts on a basis of reciprocity.

S-312—To provide that the services of a chiropractor shall be considered as medical and surgical services under the Workmen's Compensation Act, health and accident, disability, sickness or other insurance policy, or labor-management trustee; union welfare and other plans and insurances. *DISAPPROVED, WITH ACTIVE OPPOSITION IF BILLS MOVES,* because chiropractors receive a limited license to practice chiropractic. They are not licensed or recognized as physicians or surgeons and are not qualified — or licensed — to supply medical and/or surgical services for injuries and/or disease conditions.

S-313—To provide for reimbursement for chiropractor services under any group accident and/or health insurance policy or contract. *DISAPPROVED,* as unnecessary, since the chiropractor is already entitled to payment for services rendered under any insurance policy which covers chiropractic services.

S-314—To provide that the practice of chiropractic shall be covered under the provisions governing Medical Service Corporations. *DISAPPROVED, WITH ACTIVE OPPOSITION IF BILL MOVES,* because the services which chiropractors are licensed to provide are not among the services covered by Medical Service Corporations. They are not licensed or recognized as physicians or surgeons and are not qualified — or licensed — to supply medical and/or surgical services for injuries and/or disease conditions.

S-315—To provide for reimbursement for chiropractor services under any policy of accident and sickness insurance. *DISAPPROVED* as unnecessary, since the chiropractor is already entitled to payment for services rendered by him under any insurance policy which covers chiropractic services.

*S-333—To provide that any resulting disease of the respiratory system of a member of a paid fire or police department shall he deemed an occupational disease. *DISAPPROVED,* because it involves diagnosis by legislative enactment rather than by medical investigation.

*S-334—To amend Chapter 253, P.L. 1944, providing for retirement of firemen or policemen; provides that diseases of the respiratory system shall be presumed to be injuries received in the performance of duty. *DISAPPROVED,* because it involves diagnosis by legislative enactment rather than by medical investigation.

*S-335—To amend Chapter 255, P.L. 1944, providing for retirement of firemen and policemen; provides that diseases of the respiratory system shall be presumed to be injuries received in the performance of duty. *DISAPPROVED,* because it involves diagnosis by legislative enactment rather than by medical investigation.

S-345—To abolish the Air Pollution Control Commission and to transfer its functions to the Department of Health and to create a Clean Air Council of 15 members. *APPROVED*

S-346—To appropriate $1,500,000 to acquire and/or improve property in the South Jersey area to constitute a South Jersey branch of the New Jersey College of Medicine and Dentistry. *ACTION DEFERRED,* pending study and investigation.

*A-2 —To increase weekly maximum unemployment compensation and temporary disability benefits to ⅔ of average weekly wages of employees covered by the Unemployment Compensation Law; to increase total maximum benefits to 1½ of base year wages; to provide strike benefits and other changes. *NO ACTION*

A-5 —To provide for examination of medical service corporation plans of payments by the Commissioner of Banking and Insurance upon filing of a petition signed by 50 or more interested persons. *DISAPPROVED WITH ACTIVE OPPOSITION IF BILL MOVES,* because it would empower the Commissioner of Banking and Insurance to fix fees to be paid by MSP to participating physicians and would, therefore, constitute an unwarranted and unjustifiable denial of the fundamental right of the physician himself to declare — or by his own choice to authorize an agency to set — his fees for professional services rendered. Thus, it would threaten the operation of the Plan by discouraging the adherence of participating physicians and it would be in disregard of the best interests of the approximately 2,700,000 people of New Jersey who are its beneficiaries.

A-6 —To require the Commissioner of Banking and Insurance to conduct a complete examination of hospital service corporations and hospitals with whom contracted before approving schedules of rates to be paid by subscribers. *DISAPPROVED,* because—although MSNJ approves the recommendation of the Governor's Commission to Investigate Blue Cross that an audit under official auspices should be established and maintained — the Society is convinced that such audit should not be limited to the time of application for a subscription rate increase.

*A-12 —To establish presumptions in certain illnesses of firemen and policemen. *DISAPPROVED,* because it involves diagnosis by legislative enactment rather than by medical investigation.

*A-13 —To provide that any condition or impairment of health to a uniformed member of a paid fire department caused by hypertension, heart disease, or tuberculosis shall be deemed to be an occupational disease. *DISAPPROVED,* because it involves diagnosis by legislative enactment rather than by medical investigation.

*A-35 —To define legal insanity as a defense to all crimes and to provide for commitment of the mentally ill. *NO ACTION*

*A-81 —To reorganize and continue an eleven-member Air Pollution Control Commission in the State Department of Health. *NO ACTION* (in view of approval of S-345).

A-105—To provide that the Civil Service Commission may refuse to examine or certify as eligible any applicant who is mentally or emotionally disabled. *NO ACTION*

*A-106—To repeal the law granting immunity to nonprofit charitable institutions from actions for damages for injury to persons. *DISAPPROVED,* because the Society supported S-204 of 1958, which created the law A-106 seeks to repeal.

*A-170—To prohibit commitment of sex offenders to mental institutions other than those providing entirely separate facilities. *APPROVED*

*A-176—To require fingerprinting and photographing of persons arrested for any offense relating to dangerous drugs. *APPROVED*

*A-189—To increase the state scholarship to $600 in place of $500 per year. *APPROVED*

A-195—To include carbon tetrachloride in the phrase defining "glue." *APPROVED*

*A-199—To prohibit subrogation of hospital and medical service of any insurance company for any hospital or medical services. *DISAPPROVED,* in support of the position of Medical-Surgical Plan of New Jersey and the recommendation of the Dumont Commission.

A-228—To provide for an "Air Pollution Emergency Control Act." *NO ACTION*

A-229—To provide there shall be no presumption that a driver's liability to operate a motor vehicle is impaired if there is in excess of 0.05% but less than 0.10% by weight of alcohol in the defendant's blood. *APPROVED*

A-230—To require all municipalities to acquire a suitable device for measuring the amount of alcohol in a person's blood by taking a sample of his breath and to have at least one qualified officer capable of operating such device. *APPROVED*

A-237—To provide for exemption under the "Sales and Use Tax Act" certain restaurant food, all medicine and drugs for human consumption, sewer service, and soaps and detergents, paper towels, napkins, and tissues. *APPROVED*

A-254—To require protective helmets for motorcycle operators and passengers. *APPROVED*

*A-266—To expand the "Good Samaritan Act" to include all persons who extend emergency aid. *DISAPPROVED,* because it would expose victims of accidents to serious danger in consequence of well-meant but incompetent ministrations that could do more harm than good.

A-292—To provide for physical fitness re-examination of motor vehicle licensees at least once every three years. *ACTION DEFERRED,* pending study and recommendation by the Special Committee on Traffic Safety.

A-293—To require motorcycles and motorcycle drivers to be equipped with certain equipment and to prescribe for supervision of learner-drivers of automobiles and motorcycles and to provide for inspection of motorcycles. *APPROVED*

*A-321—To require every employer of 75 or more employees to provide adequate medical care or attention for all injuries arising out of, and in the course of, such employment; to require a registered nurse on the premises of employers employing less than 200 employees; and where 200 or more are employed, to require the presence of a duly licensed physician at all times such employment is in operation. *DISAPPROVED,* because — although the declared purposes of the bill are commendable — the stipulated requirements are impossible of fulfillment in view of the limited number of nurses and practitioners in New Jersey.

A-334—To provide for suspension, revocation, or prohibition of motor vehicle licenses for persons convicted under the uniform narcotic drug law. *NO ACTION*

*A-335—To provide immunity from civil damage suits to volunteer first-aid or rescue squad workers who are not members of a volunteer fire company. *APPROVED*

*A-346—To transfer certain approval powers over hospital service corporations from the Commissioner of Institutions and Agencies to the Commissioner of Banking and Insurance. *NO ACTION*

*A-362—To include the crimes of "incest" and "private lewdness" within the category of those offenses which require examination of the individual at the Diagnostic Center. *APPROVED*

*A-369—To permit recovery of hospital, medical, and funeral expenses incurred for one wrongfully killed. *NO ACTION*

*A-389—To provide for a program for control of depressant and stimulant drugs and the commitment and treatment of drug addicts by establishing a State Narcotic Control Commission in the executive department of state government. *DISAPPROVED,* because of substantial and technical defects in the bill and because MSNJ supports the position of the Narcotic Drug Study Commission of the New Jersey Legislature that recently enacted legislation should be given adequate time to prove whether or not it is satisfactory.

A-394—To hold as a disorderly person one who possesses or sells any instrument or medicine designed to cause unlawful abortion. *DISAPPROVED,* because, although MSNJ approves the first stipulation to protect against the selling of instruments to cause unlawful abortion, this measure would invest authorized pharmacies or drug stores with the exclusive right to sell or distribute "any instrument, medicine, or other thing for the prevention of conception," in disregard of the licensed physicians' proper rights and responsibilities.

A-410—To establish the "State Uniform Dog Control and Licensing Act of 1967." *DISAPPROVED,* because of its many undersirable provisions, but chiefly because it would unjustifiably transfer a basic public health program — the prevention of rabies in humans and animals — and its supporting funds, from the Department of Health, which has long been ad- to the Department of Agriculture. While disapproving A-410, the Society approves A-686 as sounder and more desirable legislation in this area of public concern.

*A-422—To prohibit persons from placing, turning or draining, or placing where it can run, flow, wash, or be emptied into the Delaware River above or below Trenton Falls, any explosive, deleterious, or poisonous substances. *APPROVED*

*A-424—To prohibit persons from placing, turning or draining, or placing where it can run, flow, wash, or be emptied into any of the fresh tidal waters within the state, any deleterious or poisonous substances of any kind. *APPROVED*

A-427—To hold as a disorderly person one who detains or impounds any stray cat or dog with intention to sell such animal for experimentation. *DISAPPROVED,* because MSNJ supports A-686, which it considers to be a superior measure.

A-459—To provide for physical and mental examination of students expelled from a public school for more than seven days. *DISAPPROVED* as impractical and unnecessary, since provision is already made for routine examinations in schools.

A-480—To provide that boards of education may require immunization against measles as a prerequisite to school attendance. *APPROVED*

A-487—To authorize a municipality to contract to provide health services to any non-profit private school. *APPROVED*

A-559—To prohibit sale or distribution of any egg products for human consumption unless such products have been pasteurized. *NO ACTION*

A-600—To expand mental health services. *ACTION DEFERRED,* pending study and investigation.

A-607—To provide that information to the State Board of Medical Examiners by applicants for examination shall include a declared intention to become a citizen of the United States. *ACTION DEFERRED,* pending study and report by the special committee of the Board of Trustees.

The Council was unanmious in its agreement that this is desirable legislation.

A-665—To authorize the Air Pollution Control Commission to prohibit, restrict, or condition — permanently or for a specified period — any activity whose contribution to air pollution would be a health or safety risk. *NO ACTION*

A-666—To authorize a governing body to prescribe penalties for violation of air pollution control ordinances, but not in excess of those prescribed in Chapter 212, Laws of 1954, Section 19. *ACTION DEFERRED,* pending study and investigation.

A-677—To create a clean water council of 17 members in the State Department of Health. *ACTION DEFERRED,* pending study and investigation.

A-686—To provide for permanent registration markings on dogs, transportation of animals, maintenance fees for seized and detained dogs; and to provide for release of unlicensed dogs to individuals or authorized institutions conducting experiments. *APPROVED*

Privileged Communication

Despite the intensive campaign of active opposition against Assembly Bill 325 waged by the Society during the year, the "practicing psychology act" became law (Chapter 282, P.L. 1966). As an Administration-favored measure, this bill apparently was bound to pass despite the efforts of organized medicine. Under this new law, psychologists were granted "privileged communication." In view of the precedent established in this legislation, the Board directed that the Council review the measure as signed into law from the standpoint of its granting confidentiality to psychologists and to prepare legislation to achieve confidentiality on the same principle for doctors of medicine. In furtherance of the Board's directive, the Council submitted an appropriate draft which will be introduced in the Legislature at the appropriate time.

Statewide Medical Examiners' System

On November 23, 1966 — at the invitation of the Attorney General — representatives of MSNJ met informally at the Attorney General's office, to discuss with him the Society's proposal for the establishment of a statewide medical examiners' system. At this conference, the Attorney General pointed out that a compromise on the part of MSNJ in arriving at acceptable legislation would be necessary, and that therefore the legislation would not emerge with all the features recommended by MSNJ. The Attorney General informed the conferees that the Administration measure was in process of preparation and would be forthcoming. As this report goes to press, such a bill (A-785) has been introduced. It will be dealt with by the Council at its May meeting and be reflected in the Council's supplemental report to the House.

Medical and X-Ray Technicians

On October 14, 1966, representatives of MSNJ met informally with Miss Beatrice Tylutki, assistant counsel to the Governor, to discuss the Society's proposed legislation to afford legal protection to qualified individuals who supply limited technical assistance to physicians in the care and treatment of their patients, and to call her attention to the peremptory need for the realization of the ends which the proposed legislation seeks to attain. Miss Tylutki assured the conferees that she understood the Society's goals and felt that it would be possible to produce an acceptable version for introduction early in this year's session of the Legislature. Under date of January 30, 1967, a letter was addressed to the Governor, outlining the steps thus far taken by the Society with members of his staff, and requesting his early assistance in bringing about his promised Administration-sponsored legislation in this area.

Despite repeated urgings to the Governor's office, no reply as yet has been forthcoming.

Licensure of Foreign Interns and Citizenship

At the request of the Board, the Council submitted an appropriate draft which would make it possible for foreign medical school graduates to sit for examination for temporary licensure upon declaration of intention to become citizens. Subsequently, Assembly Bill 607 was introduced, which is identical to that drafted by the Council.

Specialty Societies

Request was made of the Board of Trustees at its December (1966) meeting that it take "prompt and effective action in order to include at least one member (of the Neuropsychiatric Association) on the Legislative Council of The Medical Society of New Jersey."

The Board pointed out that, under MSNJ Bylaws, the Council on Legislation consists of 12 members — six of whom shall be elected by the House of Delegates and six appointed by the President — each for a three-year term. There is at least one elected and one appointed member from each Judicial District. The Bylaws provide that candidates may be appointed by the President in the district in which a vacancy exists. The Bylaws also list the primary function of the Council, which is to study and evaluate legislation "proper to the interests of this Society."

The Board also took occasion to point out that it is not — and never has been — the function of committees or councils of the Society to represent specialty organizations. Since the Society is made up of members of many specialty groups, it would be discriminatory and unfair to favor one over the other.

The Board was unanimous in its conclusion that adequate provision is made for component societies to elect from the House — or to call to the attention of the President — any members whom they feel could well serve MSNJ on councils or committees. The Board was unanmious in denying the request of the Neuropsychiatric Association.

To assist specialty societies in making suggestions concerning legislation relevant to their interests, however, the Board unanimously agreed that specialty societies could be invited to send one or two representatives to those meetings of the Council on Legislation in which legislation may be considered affecting their interests. The Board empowered the Executive Director to extend this invitation to all such specialty societies at the appropriate time.

National Legislation

On the national scene, the Council is guided by the positions and recommendations of the American Medical Association. The Council gave particular attention this year to P.L. 89-544, the purpose of which is to impose such controls on animal dealers as will eliminate the evil commerce in stolen dogs and cats. Control rests with the U.S. Secretary of Agriculture, who is empowered to establish standards to govern the humane handling, care, treatment, and transportation of animals by dealers and research facilities. The final draft adopted by Congress was the result of many conference with, and suggested amendments proposed by, the AMA.

Supplemental Report

The Council on Legislation is scheduled to meet in early May. The results of this meeting will be the basis for a supplemental report to the House, to bring the members up to date on current state legislation.

Approved (page 408)

Supplemental Report

Since preparation of its Annual Report for advance distribution to the House, the Council has had another meeting (May 4) to supply recommendations concerning state legislation recently introduced. In addition, definite action has been taken on other items of interest to the membership.

Licensure of Foreign Interns and Citizenship

In its earlier report, the Council called attention to Assembly Bill 607 — which would make it possible for foreign medical school graduates to sit for examination for temporary licensure upon Declaration of Intention to become citizens. This measure is identical with legislation drafted by the Council, at the direction of the Board of Trustees.

Recently representatives of MSNJ met with representatives of the State Board of Medical Examiners to ascertain whether or not A-607 should be amended to include a provision which would require surrender of a license if, at the end of six years, the Declaration of Intention had not resulted in the attainment of citizenship. Legal Counsel for the Society supported the contention of the Council's Legislative Analysis that provision already exists in current law which would require surrender of a license if Declaration of Intention has not culminated in the attainment of citizenship. Thus, the official position of the Society concerning A-607 is one of approval.

As the Legislature goes into recess until November 20, this measure is still in the Assembly Committee on Revision and Amendment of Laws.

Statewide Medical Examiners' System

The Council studied at length the Administration-sponsored proposal for a Statewide Medical Examiners' System (A-785). It reviewed a comparative analysis prepared by the Legislative Analyst of the proposal recommended by MSNJ and the provisions of A-785. The Council took into consideration the objections to A-785 recorded by the New Jersey Society of Pathologists as well as by the Monmouth County Medical Society. After detailed discussion and review, the Council was unanimous in its opinion that, even though A-785 does not contain all the provisions requested by MSNJ, it is a compromise that is more acceptable than the present plan of county coroner. Moreover, the Burlington County Medical Society — the original sponsors of a resolution in the 1964 House of Delegates calling for the establishment of a Statewide Medical Examiners' System—seemed satisfied that this measure was a step in the right direction. The Council, therefore, recommended approval of A-785. This position was sustained by the Board of Trustees.

Assembly Bill 785 passed in the Assembly on May 1 and in the Senate on May 8. It is expected that Governor Hughes will sign the measure into law without delay.

Statewide Medical Examiners' System
As Proposed By

The Medical Society of New Jersey	*Assembly Bill No. 785*
1. System administered by State Department of Health.	System administered by Department of Law and Public Safety (section 2).
2. Policy set and appointment of Chief Medical Examiner (who must be a qualified forensic pathologist) made by a Commission consisting of:	State Medical Examiner appointed by Governor with Senate consent for 5-year term. Medical Examiner "must be a duly licensed physician, graduate of regularly chartered and legally constituted medical school and a qualified forensic pathologist (section 2).
	Policy recommended no appointment power by Advisory Committee consisting of:
(a) Commissioner of Health	(a) Same
(b) Attorney General	(b) Same
(c) Superintendent of Police	(c) Same
(d) Professors of Pathology of N.J. medical schools	(d) Chairmen of Departments of Pathology of N.J. medical schools
(e) President of MSNJ	(e) Two New Jersey citizens appointed by Governor with Senate consent for 5-year term (section 5)
(f) President of New Jersey Bar Association	
Chairman: Commissioner of Health	Chairman: Attorney General (section 5)
Secretary: none suggested	Secretary: State Medical Examiner (section 5)
Serve without compensation	Same
3. Chief Medical Examiner to set up a Central and two regional offices and be in charge of central office; Assistant Medical Examiners in charge of regional offices.	Attorney General to provide State Medical Examiner with "such laboratories, furniture, equipment, records, and supplies as may be needed." Attorney General empowered to "enter into agreements with the State Department of Health or with any state-operated

	college or school of medicine or public hospital for the use of certain laboratories, morgues, and other technical facilities and space in its buildings as offices and laboratories for the State Medical Examiner and his staff" (section 4). This section also provides that the "State Medical Examiner and his assistants may be made available to such educational institutions for the teaching of legal medicine and other subjects closely related to their duties."	6. Powers of Deputy Medical Examiners:	County Medical Examiner empowered, subject to approval of Board of Chosen Freeholders, to appoint and prescribe "the duties of such deputy or assistant county medical examiners and other personnel required for the proper performance of the duties of the office."
		None prescribed by MSNJ	Deputy and assistant County Medical Examiners "shall be licensed physicians and possess such qualifications as shall be determined by the County Medical Examiner after consultation with the State Medical Examiner" (section 7).
4. Medical Examiner recommends Chief Toxicologist to Commission for appointment. Main Toxicology Laboratory to be located as to assure best working harmony between Medical Examiner and Toxicologist.	"Attorney General shall, subject to provisions of Title 11 of the Revised Statutes relating to Civil Service, appoint such other personnel as he may consider necessary for the efficient work of the division" (section 2). *Note:* Physicians are not obliged to submit to examination for appointment under Civil Service laws, but they would be entitled nevertheless to all fringe benefits: pension, sick leave, hospitalization, etc.	7. Chief Medical Examiner to determine what cases are to be reported to his office.	All cases to be reported to State Medical Examiner office . . . those where cause of death is established beyond reasonable doubt and those requiring autopsy. State Medical Examiner, Assignment Judge of Superior Court, Prosecutor, or Attorney General may request autopsy in any case (section 11).
		Chief Medical Examiner "will be personally responsible for investigating or delegating investigation of each case."	County Medical Examiner submits full report of all deaths whose cause is established beyond reasonable doubt to State Medical Examiner. If in "opinion of County Medical Examiner, State Medical Examiner, Prosecutor, Superior Court Judge, or Attorney General an autopsy is necessary, the same shall be performed by (1) State Medical Examiner or an Assistant designated by him; or (2) the County Medical Examiner or a deputy or Assistant County Medical Examiner, provided either has the recognized training or experience in forensic pathology; or by (3) such competent forensic pathologists as may be authorized by the State Medical Examiner" (section 11). Duty of physician in attendance, any law enforcement officer having knowledge of certain deaths to notify County Medical Examiner and County Prosecutor. Immediately upon such notification, County Medical Examiner or his deputy or assistant shall go to body and take charge of same (section 10).
5. Deputy Medical Examiners to be appointed by Chief Medical Examiner from lists submitted by component chapters of MSNJ. (Paid on fee-per-case basis: $10) Deputy to investigate deaths in county.	County Medical Examiners to be appointed and salary fixed by Board of Chosen Freeholders (section 6 and 8).		
	Same as MSNJ		
No term prescribed	Appointment for 5-year term		
No qualifications set for Deputy Medical Examiners	All appointees must meet qualifications as established by rule or regulation of the State Medical Examiner (section 6). Two or more counties may jointly maintain the office of county medical examiner on a cooperative basis (section 6). If the Board of Chosen Freeholders fails to appoint, or the office of County Medical Examiner becomes vacant for any other reason, the State Medical Examiner may appoint one of his assistants to perform duties (section 6).		

Deaths to be investigated were not prescribed by MSNJ.	Section 9 directs the following deaths be investigated: (a) Violent deaths, whether apparently homicidal, suicidal, or accidental, including but not limited to death due to thermal, chemical, electrical, or radiation injury and deaths due to criminal abortion —whether apparently self-induced or not. (b) Deaths not caused by readily recognized disease, disability, or infirmity. (c) Deaths under suspicious or unusual circumstances. (d) Deaths within 24 hours after admission to hospital or institution. (e) Deaths of inmates of institutions maintained in whole or part by state or county, including prisons. (f) Deaths from causes which might constitute a threat to public health. (g) Deaths relating to disease resulting from employment or accident where employed.
8. Chief Medical Examiner office to maintain a car pool to pick up cases for autopsy.	This provision covered by item 3 and item 6 as described above. Also, "The Board or Boards of Chosen Freeholders shall provide suitable quarters and equipment necessary for the performance of the duties of the office of county medical examiners" (section 8).
9. Chief Medical Examiner to make an annual report for submission to Medical Examiner's Commission.	No provision for annual report. But all state agencies are obliged to submit detailed reports of activities for purposes of budget requests. Furthermore, Section 15 of this bill requires "full and complete records" of every death reported. These reports are the same as would be required under MSNJ proposal.

Provisions of A-785 not proposed by MSNJ:

1. Offices of coroner, county physician, and chief medical examiner abolished and powers and duties thereof transferred to office of county medical examiner (section 16).

2. Incumbents of office of county physician and chief medical examiner only (coroner not included) permitted to finish their term of office (section 6).

3. State Medical Examiner shall have general supervision over all county medical examiners. "He shall promulgate such rules and regulations as he may deem necessary to effectuate the provisions of this act." (section 3).

4. State Medical Examiner, Assistant State Medical Examiners, and County Medical Examiners granted power to administer oaths, take affidavits, and make examinations as to any matter within the judisdiction of their respective offices (section 14).

5. Expenses for transportation of a body for autopsy by State Medical Examiner, Assistant State Medical Examiner, or a pathologist authorized by State Medical Examiner as well as such reasonable fee for such pathologist as may be authorized by State Medical Examiner to be paid for by the State (section 11).

6. In cases of apparent homicide or suicide or of accidental death, the cause of which is obscure, the scene of the event shall not be disturbed until authorization by the medical examiner in charge is given. This could be the State, Assistant State, or County Medical Examiner, depending upon the facts of each particular case. For the most part, it would be the County Medical Examiner (section 13).

Resignation of Dr. Ludwig L. Simon

The Council accepted, with regret, the resignation of Doctor Simon of Newark, who for 12 years was a member of the Council. His vacancy will be filled by the House of Delegates.

Current State Legislation

The following bills have been dealt with by the Council since its original report to the House, and the Society's position as approved by the Board of Trustees at its May meeting is here presented:

S-19 —To create the Division of Postmortem Examiners in the State Department of Health. *No Action* (See A-785)

S-57 —To provide that Sections 1 and 2 of Chapter 170, Title 2A (concerning drugs), shall not apply to licensed medical practitioners acting in the regular course of their profession. *Approved*

S-346—To appropriate $1,500,000 to acquire and/or improve property in the South Jersey area to constitute a South Jersey branch of the New Jersey College of Medicine and Dentistry. *Approved*

*S-356—To extend coverage of the Workmen's Compensation Second Injury Fund to include all disabilities which are likely to be a hindrance to employment; to provide for employer reimbursement of payments exceeding 104 weeks of benefits; to provide for hearings; and to increase the fund to $3,000,000 in place of the present $1,500,000. *Approved*

S-357—To authorize the Board of Governors of Rut-
A-707—gers State University to develop the Rutgers Medical School from a 2-year to a 4-year institution by 1972. *Approved*

S-359—To provide for establishment of an Interstate

Sanitation Commission for control of future pollution and abatement of existing pollution in the tidal and coastal waters of adjacent portions of the signatory states. *No Action* (See S-443 and A-677)

S-360—To delete certain appointment privileges and to provide for appointment of public members to the Board of Barber Examiners; Board of Examiners of Nurses; and Board of Examiners of Ophthalmic Dispensers and Ophthalmic Technicians; the section concerning public members shall also apply to Boards of Certified Public Accountants; Architects; Beauty Culture Control; Electrical Contractors; Dentistry; Mortuary Science; Professional Engineers and Land Surveyors; Medical Examiners; Optometrists; Nursing; Pharmacy; Professional Planners; Psychological Examiners; Real Estate Commission; Shorthand Reporters; and Veterinary Medical Examiners. *Disapproved, With Active Opposition if Bill Moves . . .* because professionally unqualified lay members would encumber the boards, with no appreciable advantage to the public.

S-369—To provide that contracts or agreements entered into by the Board of Trustees of the New Jersey College of Medicine and Dentistry may require the municipality to undertake obligations and duties to be performed subsequent to the expiration of the term of office of the elected governing body which entered into, or approved, the contract or agreement. (Law, Chapter 18) *Approved*

*S-385—To provide that the services of the chiropractor shall be considered medical or surgical services under the Workmen's Compensation Act, any health and accident, disability or other insurance policy, or under any labor management trustee, union welfare, employee benefit, or any private insurance or welfare plans. *Disapproved, With Active Opposition if Bill Moves . . .* because chiropractors receive a limited license to practice chiropractic. They are not licensed or recognized as physicians or surgeons and are not qualified — or licensed — to supply medical and/or surgical services for injuries and/or disease conditions.

S-397—To provide for civil commitment of drug addicts. *Approved*

S-408—To provide that any applicant for a license to practice medicine and surgery who, in addition to other required proofs necessary to be admitted to examination, shows he has engaged in the practice for 10 years and has reached a position of eminence in his profession shall be granted a license without further examination upon payment of the required fee. *Disapproved . . .* because it would mandate present discretionary powers of the Board of Medical Examiners, with no constructive purpose.

S-409—To provide state aid to the extent of one-half of the operating expense of schools of professional nursing of $600 per student, whichever is the lesser amount. *Approved*

S-443—To create a "Mid-Atlantic States Air Pollution Control Compact," creating a regional agency for the control and abatement of air pollution and other purposes; and defining the functions, powers, and duties of such agency. *Approved*

S-447—To mandate use of safety equipment on motorcycles, to authorize the Director of Motor Vehicles to adopt rules and regulations; and to provide for inspections. *Approved*

S-464—To repeal an act imposing an excise tax upon the gross receipts of unincorporated businesses approved June 17, 1966. *Approved*

S-475—To provide immunity from liability to registered members of the National Ski Patrol System where emergency first-aid and rescue services are performed. *Approved*

A-292—To provide for physical fitness re-examination of motor vehicle licensees at least once every three years. *Disapproved . . .* because the measure is unclear as to its content and impractical in terms of fulfillment.

A-600—To expand mental health services. *Approved*

A-607—To provide that information to the State Board of Medical Examiners by applicants for examination shall include a declared intention to become a citizen of the United States. *Approved*

A-666—To authorize a governing body to prescribe penalties for violation of air pollution control ordinances but not in excess of those prescribed in Chapter 212, Laws of 1954, Section 19. *Approved*

A-677—To create a clean water council of 17 members in the State Department of Health. *Approved*

A-705—To provide for various exemptions under the New Jersey "Sales and Use Tax Act." (Law, Chapter 25) *Approved*

A-710—To provide that no person shall deliver potable water to any consumer which does not conform to the standards for potable water of the State Department of Health as established by regulation. *Approved*

A-731—To provide for appointments to the State Board of Examiners of Nurses. *Disapproved . . .* because professionally unqualified lay members would encumber the Board with no appreciable advantage to the public.

A-751—To define trademark and the counterfeiting thereof concerning drugs, cosmetics, and devices; to place enforcement in the Department of Health. *Action Deferred . . .* pending investigation of an amendment to the measure.

A-783—To define "local board of Health;" to authorize freeholders to establsh, after public hearing, a county board of health by resolution and to provide for appointment of persons thereto. *Approved*

A-785—To create the Division of State Medical Examination in the Department of Law and Public Safety; to establish the office of county medical examiner, and to abolish the county offices of coroners, county physicians, and chief medical examiners. *Approved*

A-794—To prohibit use of personality tests and psychological investigations in connection with public employment, renewal of a driver's

license, or with an application for automobile liability or other insurance. *No Action*

A-811—To provide that ear piercing shall be construed as the practice of medicine and surgery. *Action Deferred* . . . pending investigation and report.

A-853—To provide for reimbursement for services performed by a duly licensed practicing psychologist for a person covered by a group accident, group health, an da group accident and health insurance policy. *Disapproved,* as unnecessary . . . since the psychologist is already entitled to payment for services rendered under any insurance policy which covers the services of a psychologist.

A-854—To provide for reimbursement for services performed by a duly licensed practicing psychologist for a person covered by any policy of accident and sickness insurance. *Disapproved,* as unnecessary . . . since the psychologist is already entitled to payment for services rendered under any insurance policy which covers the services of a psychologist.

A-856—to provide for reimbursement for services performed by a duly licensed practicing psychologist for a person covered under a medical service plan. *Active Opposition* . . . because the services which psychologists are licensed to provide are not among the services covered by medical services corporations. Psychologists are not licensed or recognized as physicians or surgeons, and they are not qualified or licensed to supply medical or surgical services in treatment of injuries and/or disease conditions—the professional services compensable under coverages supplied by medical services corporations.

A-894—To provide for the development of a program of medical and dental education through establishment of a medical and dental college of South Jersey. *Approved*

A-901—To authorize freeholders to establish programs of education in narcotics law enforcement and control to be administered by county prosecutors. *Approved*

A-910—To provide for the appointment of a five-member chiropractic committee to control and regulate the ethical practice of chiropractic and impose sanctions against unprofessional and unethical conduct. *Disapproved, With Active Opposition if Bill Moves* . . . because present licensing of chiropractors under direction and control of the State Board of Medical Examiners is preferable in the public interest. Moreover, this legislation attempts to identify the chiropractor as a "physician," a title to which he has no claim on the basis of training or licensure.

As this report goes into print, the Legislature has announced its adjournment until November 20 at 2:00 p.m. As one of its final actions in this session, resolutions were adopted in the Senate and Assembly directing that "all unpassed bills and resolutions pending be recommitted to the standing committee to which they were originally referred and that all unpassed bills held without reference be referred to the Committee on Revision and Amendment of Laws."

Approved (page 408)

Public Relations

Harry F. Suter, M.D., Chairman, Penns Grove
(Reference Committee "E")



The Council on Public Relations has for a long time held the conviction that no one can do as much for the improvement of all aspects of public relations for the medical profession as can the doctor himself. For successful medical public relations, there is one indispensable person, the individual practitioner. The following activities were taken care of as basic to the year's public relations projects.

Future Physicians' Clubs

As the result of a questionnaire circulated among the component societies, a compilation was made of replies and materials submitted on the existence of Future Physicians' Clubs at local level. Out of 21 component societies, only seven reported active, successfully functioning clubs. The compilation was sent to those 14 component societies that reported either inactive clubs or none at all, with the recommendation that efforts be made to establish a Future Physicians' Club at local level.

Newspaper Publicity

The Council noted that, at local level, physicians and the profession are sometimes the subjects of complimentary newspaper articles and/or editorials. The Council requested the cooperation of component societies in bringing to the attention of MSNJ, for appropriate reflection, such newspaper citations. The Council urged that prompt action be taken at county level to acknowledge and indicate appreciation of published items.

Health Hints

With the continued expansion of syndicated health columns in newspapers, MSNJ's biweekly *Health Hints* seemed to the Council to have outlived their usefulness. The Council reviewed a summary analysis based on newspaper clippings received for a five-month interval and concluded that the service was no longer necessary or desirable. The Council therefore recommended to the Board of Trustees that the issuance of the *Health Hints* be discontinued as of November 1, 1966. The Board approved the recommendation.

Junior Health Hints

With the distribution last Fall of Series 4 of the *Junior Health Hints,* the Council considered the desirability of initiating a new series or repeating the entire sequence (Series 1 through 4) again. The Council unanimously agreed that the enthusiastic reception each year of the series as it exists more than justified its repetition. It agreed to up-date the current series with such additions and revisions as are necessary and repeat the *Junior Health Hints* — Series 1 through 4 — for the school years 1967-1971.

Golden Merit Award

A total of 29 members received the 1966 Golden Merit Award — 18 of whom were present in Atlantic City for the bestowal ceremonies. Since its establishment in 1957, a total of 456 members have received this award. Thus far for 1967, a total of 39 candidates have been approved as eligible for the award. By policy decision of the Board of Trustees, any candidate for the Golden Merit Award who is alive as of January 1 of the fiftieth year following attainment of his M.D. degree will be granted the award. If an eligible candidate dies between January 1 and the date the award is made, the plaque will be sent to his family posthumously. This year, two awards will be made posthumously.

Continuing Projects

With the approval of the Board of Trustees, the following continuing and special projects and activities were administered under the Council's sponsorship:

1) Publication and distribution of:

 a) *Junior Health Hints* (Series Four) to schools and public libraries

 b) *Membership News Letter,* including the annual compilation of a bound, indexed set to component societies

 c) *Periodic Newsletter* to cooperating agencies and individuals

2) Preparation and publication of special news releases and publicity as required from time to time, in furtherance of the Society's business and interests, including:

 a) 1966 Eye Health Screening Program

 b) 1967 Annual Meeting

 c) Child Safety Week

 d) Selected official programs and activities

3) Responsibility for the bestowal of the Golden Merit Award

4) Responsibility for the press room at the Annual Meeting

6) Encouragement of indoctrination programs under the sponsorship of the component societies

7) Encouragement of statewide emergency medical care coverage particularly with reference to the Basic Concepts Underlying the Provision of Professional Medical Care as adopted by the House of Delegates

8) Encouragement of Future Physicians Clubs in each county through service as a clearinghouse at state level

Howard C. Pieper, M.D.

The Council in March accepted with regret the resignation of Dr. Howard C. Pieper of Monmouth County, who moved out of state. Dr. Pieper served as a conscientious and effective member of the Council for many years.

Approved (page 409)

Medical Services

Nicholas E. Marchione, M.D., Chairman, Vineland
(Reference Committee "F")



The Bylaws state: "The function of the Council on Medical Services shall be to study and evaluate matters relevant to the maintenance and advancement of the standards and character of medical practice in New Jersey, to investigate matters pertaining to the economic and social aspects of medical care, to report findings and recommendations to the Board of Trustees relative to official policies and positions of this Society in the field of medical service." The Board of Trustees has added to the functions of the Council on Medical Services overall responsibility to study and provide recommendations concerning (a) all aspects of the Medicare program as it operates or will operate in New Jersey; and (b) the maintenance of quality medical care.

In fulfilling these assigned functions, the members of the Council on Medical Services have been very active in the past year. Not only have the members attended the meetings of the Council but many members have also been active in serving as liaison representatives from the Council to the various organizations, institutions, and agencies dealing with the many aspects of Medicare. The following report will give in detail the work of the Council during the past year.

Over 65 Welfare Recipients

The Council carefully investigated and considered the proposal of the Division of Public Welfare concerning payments to physicians for services rendered to welfare beneficiaries over 65 years of age, on the basis of utilization and expansion of the Part "B" Medicare coverage. It subsequently brought the result of its deliberations and its recommendations to the Board of Trustees. A detailed account of this matter will be found in the report of the Board of Trustees (page 304).

Resolution #11
1966 House of Delegates

The Council received Resolution #11 of the 1966 House calling for the cooperation of MSNJ with agencies involved in the implementation of P.L. 89-97. To this end the Council has maintained active liaison with the Department of Health and the Department of Institutions and Agencies through its designated representatives. The Utilization Review Committee and the Committee on Compensation of Physicians have also been active to insure that efficient and effective care is provided and that the Principles of Medical Ethics are observed.

The Council feels that the Society is cooperating in the efforts to achieve effective implementation of the Medicare programs in New Jersey.

Resolution #15
1966 House of Delegates

This resolution, calling for the separation of professional fees and hospital charges, was referred to the Medical-Surgical Plan and the Hospital Service Plan for study and report. To date, the Council has not received a report.

The House urged continued study on the problem of separation of professional fees and hospital charges (page 411)

Resolution #20
1966 House of Delegates

A report on Resolution #20, urging the creation in New Jersey of top-level health care planning and administrative groups for the state as a whole and for its various subdivided health "regions," will appear in the

supplemental report of the Council on Medical Services.

Resolution #21
1966 House of Delegates

Resolution #21, urging the passage of implementing legislation for Title XIX, was also dealt with by the Council on Medical Services. Since the Department of Institutions and Agencies has the responsibility of planning and implementing Title XIX in New Jersey, the Council has established liaison with the Department in the persons of Francis J. Benz, M.D. and George K. Degnon of the executive staff. The Department of Institutions and Agencies has assured MSNJ that its representatives will be invited to attend any meetings and to participate in any discussions concerning the planning for implementation of Title XIX.

Compensation of Physicians for Care of Subsidized Patients
House Resolution Substite for Resolutions #5, #6, #12 and #18

The Council on Medical Services agreed with the Board of Trustees that the second resolved of this resolution, calling for public declaration of MSNJ's policy that physicians should bill subsidized patients on their usual and customary fee-for-service basis, had already been implemented by release of this resolution to the public media through the open session of the House.

Utilization Review Committee

The recommendations of the Council on Medical Services approved by the 1966 House of Delegates — that a Utilization Review Committee be established in each county and that names of the chairmen and other personnel be sent to the Council on Medical Services by the component societies — have been implemented.

The Council on Medical Services held a joint meeting with the Utilization Review Committee chairmen from the component societies.

The purpose of this conference was to give the chairmen a fuller understanding of utilization review in hospitals and extended care facilities and to discuss informally the difficulties associated therewith. As a result of this meeting, Dr. David Eckstein of Trenton, Chairman of the Committee on Utilization Review, prepared an interpretation of the procedures to be followed in establishing Utilization Review Committees for the extended care facility which was subsequently presented to the membership of MSNJ in a supplement to the Christmas *Membership News Letter.*

Miscellaneous

The question of labeling prescription drugs was considered during the past year and, at the instigation of the Council on Medical Services, the Board of Trustees issued the following policy statement:

That frequently it is in the best interest of patients to label prescription containers with the names and strengths of contained drugs, but that fundamentally the final decision rests with the physician to designate whether or not the container should be so labeled.

The Board of Trustees also approved the following recommendation of the Council:

That the Physician's narcotic registration number *not* be imprinted on his prescription forms.

The House reiterated previous recommendations that physicians' narcotic registration numbers not be imprinted on prescription pads. (page 412)

The Council on Medical Services will submit a supplemental report to the 1967 House of Delegates. At the time of this writing, another meeting of the Council is scheduled to be held in addition to a joint conference with representatives from various specialty groups for the purpose of exploring Title XIX to determine the specific areas of interest and concern for MSNJ and to blueprint our goals and plans. It is the purpose of the Council to crystallize and consolidate the aims and desires of all our members and groups of members so that MSNJ will be able to adopt positions representative of, and acceptable to, all in the process of implementing Title XIX.

Approved (page 412)

Supplemental Report

The Council on Medical Services met on April 12, 1967, subsequent to the submission of the annual report, and herein are reported significant actions taken at this meeting.

Resolution #20 — 1966 House of Delegates

Resolution #20, Urging the Creation in New Jersey of Top-Level Health Care Planning and Administrative Groups for the State as a Whole and for Its Various Subdivided Health "Regions," has been under study by the Council. The Comprehensive Health Planning and Public Health Service Amendments of 1966, introduced as S. 3008, were signed into law on November 3, 1966, as Public Law 89-749.

Governor Richard J. Hughes has designated the State Department of Health as the agency in New Jersey to administer the state's health planning functions under a plan to be developed in conformity with P.L. 89-749. The Council is eager to participate in all aspects of health care planning and services so that it will be able to keep abreast of the changing concepts in health care services, so that it will have a clear picture of governmental health care programs for the guidance and future action of MSNJ, and so that governmental health care programs will not interfere with the private practice of medicine.

In P.L. 89-749 the term "public health services" has little restrictive meaning, if any. Charles Hudson, M.D., President of the American Medical Association, pointed out in his testimony on S. 3008 before the House Committee on Interstate and Foreign Commerce, "In the absence of definitive language, this legislation could represent a far reaching departure, or expansion, from the truly public health services with which the Public Health Service has been charged. The legislation provides what appears to be unlimited health services, focused on individuals and families rather than on separate disease conditions. It brings within the guise of public health services the medical and health services presently being provided by the individual physician to the individual patient."

The Council is of the opinion that a conference of selected representatives of MSNJ with the Commissioner of Health would help to determine New Jersey's commitment to the comprehensive health planning and public health services program. To this end, the Council recommended and the Board of Trustees approved that, in furtherance of MSNJ's already-expressed desire to participate in all aspects of health care planning and services in New Jersey, the Chairman of the Council on Medical Services be authorized to arrange a special meeting with the Commissioner of Health and such representatives of his department — or other state departments — as he suggests and selected members of the Council, for the purpose of discussing the present status and the proposed implementation of P.L. 89-749 in New Jersey. Arrangements for this conference are presently being made.

The Council is of the opinion that The Medical Society of New Jersey should be apprised of the full impact of this law since this legislation brings us one step closer to a universal system of socialized medicine in this country.

Advisory Group of Specialty Society Consultants

The Council recommended, and the Board of Trustees approved, that an Advisory Group of Specialty Society Consultants to the Council on Medical Services be established and that each specialty society be invited to appoint one member as official consultant-representative. The advisory group will provide each specialty society the opportunity to express its concerns in matters relevant to the maintenance and advancement of standards and character of medical practice in New Jersey and matters pertaining to the economic and social aspects of health care.

Title XIX
(Resolution #21, 1966 House of Delegates)

On April 12, 1967, the Council held a joint meeting with representatives of various specialty societies which had expressed a desire to discuss Title XIX. It was agreed at this meeting that among provisions to be actively

sought in the New Jersey Title XIX Program are: free choice of physician and hospital, usual and customary fees, the option of direct billing to the patient (providing changes in the federal legislation make this possible), and prescribing by the physician of the drug he deems best for the patient.

The Council is presently arranging for a conference with the Commissioner of Institutions and Agencies and his representatives for the purpose of the department's open discussion of MSNJ's objectives and plans for Title XIX as it will be implemented in New Jersey.

Approved (page 412)

Sub-Committees of the Council on Medical Services

Occupational Health, Workman's Compensation, And Rehabilitation

Joseph A. Lepree, M.D., Chairman, Elizabeth
(Reference Committee "F")



The Committee met during the past year with representatives of the Division of Workmen's Compensation and the New Jersey Rehabilitation Commission.

The Committee considered the problem of compensation of physicians for services rendered to workmen (state employees) under the Workmen's Compensation Law. The Committee holds that it is the right of the physician to set his own fees and not the right of a state agency, state department, or an insurance company to do so. The compensation law of the State of New Jersey reads: "All charges shall be reasonable and based upon those that prevail in the same community for similar services." Therefore, the Committee made the following recommendation to the Board of Trustees for adoption and promulgation as the official policy of MSNJ:

That the physician is entitled to his usual and customary fee whether his services are rendered to state employees or to private patients.

Since a commission to study the Workmen's Compensation Law of the State of New Jersey is being created and since medical considerations play a very important part, the Committee offered a recommendation to the Board of Trustees, which was amended to read:

That MSNJ request the Governor to appoint a representative from the Special Committee on Occupational Health, Workmen's Compensation, and Rehabilitation to the Workmen's Compensation Commission.

The Board of Trustees subsequently submitted the names of three members of the Committee to the Governor, with the suggestion that he appoint one to the Workmen's Compensation Commission.

As a result of a recommendation from the Committee, six articles dealing with workmen's compensation and industrial rehabilitation in New Jersey have appeared during the past year in *The Journal*. These articles were compiled by Jarvis Smith, M.D., who is the Medical Director of the New Jersey Rehabilitation Commission.

The chairman of this Committee officially represented MSNJ at a AMA Rehabilitation

Conference held in Chicago during the month of September. The theme of this conference was the promotion of greater cooperation between the treating physician and the local, county, state, and ultimately, the federal rehabilitation commissions.

In addition, the chairman has been appointed by the Governor as the Medical Society's representative to the Industrial Safety Board and also has been named to the Governor's Advisory Committee to the Rehabilitation Commission.

Approved (page 412)

Chronically Ill and The Aging

Matthew E. Boylan, M.D., Chairman, Jersey City
(Reference Committee "F")



As a result of the transfer last year of all business concerning Medicare to the Council on Medical Services, this year there have been no formal meetings of this committee. However, members of this committee have served in the capacity of consultants to the Council on Medical Services and have been active in the functions of the Council, particularly in matters involving Title XVIII and Title XIX.

Members of the committee have also served diligently as consultants to "Task Forces" formed by the New Jersey State Department of Health in the orientation and establishment of Home Care and Extended Care Facilities within the State of New Jersey. Their main purpose in serving in such capacities has been to guide these endeavors and to offer medical orientation to programs that have been formulated to date.

Approved (page 412)

Defensive Driving

The Travelers Insurance Company has just released its book about driving accidents. Called "Was it Sudden?", this sprightly book tells us, among other things, that excessive speed is blamed for more than 41 per cent of the highway deaths in 1966. It is the largest single factor in all fatal accidents resulting from driver error. Other major factors involving actions of drivers resulting in deaths and injuries include driving on the wrong side of the road, reckless driving, and not having the right-of-way. Drivers in 1966 were blamed for more than 80 per cent of all fatal accidents, while pedestrians, or a combination of pedestrian and driver, were found at fault in the remaining 20 per cent.

To help prevent accidents, a Travelers spokesman suggests that drivers update driving skills by taking a driver refresher course; practice defensive driving; limit driving when tired; adjust speed to highway, weather, traffic, and other conditions; and don't drive while under the influence of alcohol. He also urged motorists to support better law enforcement, highway improvement, and improved driver licensing.

Public Health

John P. Coughlin, M.D., Chairman, Jersey City
(Reference Committee "G")



Work of the Council on Public Health has been greatly expedited this year by the able and enthusiastic leadership of the chairman of the special committees under the Council. Following the report of the Council will appear the report of its special committees, giving detailed accounts of their activities.

Air Pollution Control

There is a growing awareness today of the effects of air pollution upon the health of the individual. The following policy statement was adopted by the Board of Trustees upon recommendation of the Council on Public Health:

That MSNJ record itself as encouraging and supporting all practicable measures to achieve the control of air pollutant densities at all times, but especially when dangerous index levels are reached.

Boxing Regulations

MSNJ received from the office of the State Athletic Commissioner a letter requesting an opinion on the establishment of a minimum age and other standards for boxing contests ("kid boxing"). The Council on Public Health considered this communication at length and offered the following recommendations, which were approved by the Board of Trustees:

That a complete physical examination be given to each potential contestant, with special attention to heart, good vision in both eyes, sound reflexes, normal hearing, and proportionate anatomical development. In taking the history, particular stress should be placed upon previous injuries, especially to the head. In the opinion of the Council, too much emphasis cannot be placed on the fact that the greater danger to young contestants is through head injuries and intracranial damage. For this reason the Council strongly *recommends* that protective headgear be required of those participating in such contests and that constant supervision be extended at all times, to include even matching of contestants on basis of age, height, weight, and the like.

The Council also strongly *recommends* that any contestant who suffers a knockout should be debarred from further participation in boxing until he has had a thorough physical examination, particularly with reference to head injuries, and has had full clearance from the physician in charge of his case.

House approved an additional requirement: that the minimum age for boxing be 16. (page 414)

Venereal Disease Control

The Woman's Auxiliary to The Medical Society of New Jersey requested that the Council on Public Health support a program of investigation by the Auxiliary as to the matter and extent of venereal disease control programs now going on in the schools of New Jersey, with special attention to the qualifications of personnel and the type of textbook materials being used. The Council offered the following *recommendations* to the Board of Trustees, which were subsequently approved:

1) That MSNJ re-emphasize its continuing strong support of any and all effectual educational measures to accomplish the control and elimination of venereal disease.

2) That any further action on the part of the Society toward working with the educational system of the State in venereal disease control be deferred until the reports on sex education requested of the Parents and Teachers Association, the Association of School Physicians, and the Association of School Nurses are received and evaluated.

Approved (page 414)

1968 Annual Meeting

Saturday, Sunday, Monday, Tuesday, Wednesday May 18-22, 1968
Haddon Hall, Atlantic City

Sub-Committees of the Council on Public Health

Air Pollution Control

Roslyn Barbash, M.D., Chairman, Teaneck

(Reference Committee "G")



The objectives of the Committee for the past year have been:

1) Public education in air pollution control and air conservation.

2) Continuation of physician education in air pollution control and air conservation.

3) Development of a statewide speakers' program through the component societies.

4) Support of the Governor and the State Department of Health in their efforts toward "cleaner air."

Accomplishments

Several of the county societies have conducted educational programs. Physicians are serving on advisory boards to county governmental bodies and are bringing up-to-date information to officials.

Following attendance at the National Conference on Air Pollution in Washington, D.C., an up-to-the-moment resumé was sent to the air pollution control committees of the component societies.

Support was given to "Clean Air Week," established by proclamation of the Governor and celebrated through the week of October 23. The president of MSNJ and members of the Special Committee on Air Pollution Control participated in the ceremonies attending the Governor's signing and issuance of the proclamation.

An exhibit on the role of the physician in air pollution control has been prepared and will be on display at the 201st Annual Meeting of MSNJ in Haddon Hall in mid-May. In addition, the State Department of Health has honored our request for a display on "Air Alert" and will demonstrate this important feature at the Atlantic City meeting with information and data on air quality in New Jersey.

The Board of Trustees has approved the recommendation of the Committee that a die be placed on the postage meter of MSNJ imprinting the slogan, "Help Keep The Air Clean."

Approved (page 414)

Common Poisonous Plants

You can give your patients a profusely illustrated booklet full of information on the common poisonous plants, prepared by Wyeth Laboratories. The booklet describes how to recognize the plants, how to handle them, and what to do in emergencies resulting from contact or swallowing parts of these plants. There is space in the back in which the doctor's name, or name of hospital may be written. For copies of *The Sinister Garden* write to Wyeth Laboratories, Philadelphia, Pennsylvania.

Cancer Control

John L. Olpp, M.D., Chairman, Englewood
(Reference Committee "G")



As the result of your chairman's incapacitation through the necessity of extended surgery, the work of leading the Committee on Cancer Control this year in large part devolved upon Dr. Roy T. Forsberg, vice-chairman, whose fine efforts are warmly appreciated and commended.

Tumor Registries

This is the fifth year that the tumor registry at Bergen Pines County Hospital has been collecting cancer cases from the hospitals in Bergen County. As of December 31, 1966, 9,285 cases have been registered — 2,047 having been added in 1966.

Recommendations

That the Cancer Control Committe survey all general hospitals licensed by the State of New Jersey, to determine how many cancer and tumor registries are active.

Approved (page 414)

That physicians and surgeons on hospital staffs encourage and utilize the hospital cancer program, so that more programs will meet the standards of the American College of Surgeons.

Foregoing paragraph amended as follows:

That physicians and surgeons on hospital staffs encourage and utilize the hospital cancer program, including registries, so that more programs will meet the standards of the American College of Surgeons. (page 414)

Pap Test

The Committee has continued to endorse the program of the New Jersey Division of the American Cancer Society — as publicized in *The Journal* — to promote greater utilization of the "Pap test." Members have been urged to utilize the cytology kits, which are distributed by the Cancer Society. The Committee has noted with special satisfaction the educational program initiated by the Cancer Society, encouraging physicians to do more proctoscopies and sigmoidoscopies.

Approved as amended (page 414)

Child Health

Dorothy K. Klughaupt, M.D., Chairman, Passaic
(Reference Committee "G")



This Committee submits the following report of its activities:

Boxing By Minors

Among the more interesting matters dealt with by this Committee was the letter received from the State Athletic Commissioner requesting an advisory opinion for the establishment of "a minimum age and other standards" for public boxing exhibitions by minors.

This Committee studied the question and concluded that, on the basis of inherent dangers, boxing is not a proper or desirable sport for minors and recommended that MSNJ take this position. This view was not shared by the Council on Public Health which, instead, recommended "precautions that should be taken." (A detailed account given in the report of the Council.)

Little League Football Hazards

This problem was considered by this Committee and the following recommendation was submitted to and approved by the Board of Trustees:

That MSNJ approve the establishment of a subcommittee of the Committee on Child Health to study the health hazards to young boys who participate in Little League football programs and to meet with the Football Officials Association in an attempt to establish standards for safe participation in Little League football.

This Committee dealt with sundry matters, some of which resulted in the adoption of the following recommendations by the Board of Tustees:

Child Safety

That MSNJ petition the Governor to proclaim the first week of April as "Child Safety Week," and that a program of child safety be supported at the local level by the component societies, with appropriate publicity.

(In consequence of this recommendation, Governor Hughes proclaimed the week of April 2-8 as "Child Safety Week.")

Measles Vaccine

That MSNJ reaffirm its position in support of measles immunization.

School Physicians

That MSNJ record itself as disposed to encourage, and to consider co-sponsorship of, a postgraduate course for school physicians, when a definite program is offered to school physicians and submitted to MSNJ by the Association of School Physicians.

That MSNJ send a copy of "The Report of the Committee on School Health of the American Academy of Pediatrics" to the Commissioner of Education and recommend that he make copies available to all superintendents and school physicians.

(In consequence of this recommendation, the Acting Commissioner has supplied to each County Superintendent of Schools a copy of this report.)

Approved (page 414)

Conservation of Vision

Frank B. Vanderbeek, M.D., Chairman, Paterson
(Reference Committee "G")



The Special Committee on the Conservation of Vision has had a year of vigorous and, we feel, productive activity.

Eye Health Screening Program

In September the Committee, on behalf of MSNJ, conducted the 10th Annual Eye Health Screening Program, in conjunction with the New Jersey Academy of Ophthalmology and Otolaryngology, the New Jersey State Department of Health, the New Jersey Hospital Association, and the Commission for the Blind. The ophthalmologists of the state staffed 74 centers and screened 7,402 individuals. A total of 3,876 were found to have negative results (52.36%); positive results were found in 3,526 (47.63%).

There were 404 tonometry positive results or 5.3% of the total.
There were 3,021 visual acuity positives or 40.8% of the total.
There were 322 external inspection positives or 4.3% of the total.
There were 738 ophthalmoscopically positives or 9.9% of the total.

The Committee already has begun preparation for the 11th Eye Health Screening Program, to be conducted during the week of September 17, 1967. The Board of Trustees has approved the Committee's recommendation that there be a pilot program of diabetes detection screening conducted by the New Jersey State Department of Health of several selected centers in conjunction with the 1967 Eye Health Screening Program, for the purpose of making a correlation between diabetes and glaucoma.

Also in conjunction with the Eye Health Screening Program, upon recommendation of the Committee, the Board of Trustees endorsed the grant application of Alfonse A. Cinotti, M.D., a Committee member, which application was submitted to the National Institute of Health for funds to staff and equip a mobile eye-screening unit to operate at custodial institutions, industrial plants, and the like. The Committee also approved a request of Dr. Cinotti that the principles and procedures of MSNJ's annual Eye Health Screening Program be applied to the mobile, year-round screening program.

Approved (page 414)

Resolution #8
1966 House of Delegates

The Committee implemented Resolution #8 of the 1966 House of Delegates, which called for MSNJ to endorse, recommend, and publicize the desirability of the use of safety lenses by all children. An appropriate release was prepared by the Committee, which was given wide distribution to various organizations, agencies, and the press.

Approved (page 414)

Amblyopia Detection Program

During the year 1966 the Committee sponsored a pilot program of amblyopia screening for children registering to enter school. This statewide program screened a total of 12,640 children, 1,357 of whom were referred for follow-up eye examinations. Although the total number screened was gratifying, the return of cards from examining physicians in some areas was so irregular that an analysis of the follow-ups did not prove significantly dependable.

A subcommittee was established to study the Amblyopia Detection Program of children registering for school, which was conducted last year on a pilot program basis. After studying the program in detail, the subcommittee recommended that the entire program of amblyopia screening be turned over to the Commission for the Blind and that the Committee on the Conservation of Vision cooperate with the Commission for the Blind in this program. The Committee recommended the continuation of this screening program begun in the preceding year, but the Council on Public Health disapproved this recommendation.

The Committee further recommended that MSNJ support the Commission for the Blind, in an Amblyopia Detection Program for preschool youngsters from 3 to 5 years of age, which the Commission has initiated. The Council on Public Health and the Board of Trustees approved this recommendation of the Committee.

Approved, with the following stipulation:

That MSNJ retain an authoritative voice in the direction and control of these screening programs. (page 414)

Maternal and Infant Welfare

John D. Preece, M.D., Chairman, Trenton
(Reference Committee "G")



The Special Committee on Maternal and Infant Welfare met with representatives of the New Jersey State Department of Health and in cooperation with this group revised the *Maternity Service Records* book, which the Society issues to hospitals throughout the state. This book is designed to facilitate the preparation of statistical information for the revised Maternity Services Questionnaire which the hospitals will be asked to submit annually to the Department of Health.

The usual work of the Committee, which is the study and classification of maternal deaths throughout the state, has been hampered this year, as it was last year, by the difficulty in

getting reports back promptly from the field physicians. It is possible that the present method of collecting reports on maternal deaths, which has been successful for so many years, may now have to be changed. Discussions with the New Jersey State Department of Health will continue along these lines.

In May of 1966 the Committee considered the current abortion laws in New Jersey and informally agreed that no change should be made in the laws. In February 1967 the Committee again considered the current abortion laws and submitted the following formal *recommendation,* subsequently approved by the Board of Trustees:

That no action be taken by MSNJ toward liberalizing the abortion laws of New Jersey.

Again this year the Committee intends to hold a meeting during the Annual Meeting in Atlantic City. At this time the "Obstetrical Department Standards" for the hospitals of the state will be studied and possibly revised.

Approved (page 414)

Mental Health

Edward Schauer, M.D., Chairman, Farmingdale
(Reference Committee "G")



The Committee on Mental Health has been in a transitional stage this year awaiting its formal elevation to the status of administrative council by action to be taken by the 1967 House of Delegates by adoption of necessary Bylaws amendments.

The Committee empowered the chairman to appoint subcommittees to deal with the various problem areas of mental health — alcoholism, drug addiction, and mental retardation. With the elevation of the Committee to the level of council, there will be established special committees to deal with alcoholism, drug addiction, mental retardation, mental illness of children and adolescents, epilepsy, neurological disorders, and psychiatric disorders.

The Committee has kept abreast with the developments regarding the community mental health centers. The Committee would like to point out that under P.L. 89-749 (Comprehensive Health Planning and Public Health Services Amendments of 1966) at least 15 per cent of the state's grant for public health services is available only to the state mental health authority.

The Committee has one more meeting scheduled prior to the annual meeting and will report any significant actions taken at this meeting by means of a supplemental report to the House.

Approved (page 415)

Rising Medical Costs

President Johnson has instructed Secretary Gardner to convene a conference on medical costs. Presumably this was inspired by a report made by the Department of Health, Education, and Welfare which indicated that there had been a rapid rise in medical care costs paid by the general public. Physicians may be interested in examining the report. Copies may be obtained upon request to Dr. Alice Rivlin, Deputy Assistant Secretary for Program Analysis, DHEW, Washington, D.C. 20201.

Special Committees

Emergency Medical Care

Jack R. Karel, M.D., Chairman, Hillside
(Reference Committee "H")



Since it is the function of this Committee to be concerned not only with the adequate provision of medical care in the time of nuclear attack but also to coordinate the medical care in natural disasters and other emergencies, the Committee — with the approval of the Board of Trustees (March 19, 1967)—changed its name from "Committee on Disaster Medical Care" to "Committee on Emergency Medical Care."

Many types of diasters — fires, floods, tornadoes, earthquakes, explosions — daily threaten our way of life. Therefore, our attention is being directed to these emergencies, both because they are always potentially with us and because they furnish opportunity for experience which will improve our civil defense. Physicians, individually and collectively, have the responsibility and obligation for medical preparedness against disasters of all kinds whenever they occur.

Since the public looks to the emergency departments of community hospitals for outpatient care in disasters, the Committee recommended — and the Board of Trustees approved — that the emergency medical care program, as approved by the National Research Council, be implemented by every hospital in New Jersey. Under this program, each hospital must have good coordination, communications, and counseling — with continuous daily on-going programs, not crash programs.

During the past year, this Committee met with the medical coordinators of each county for discussion of mutual medical problems of an emergency nature. At this meeting, the Deputy Director and his representatives from the Division of Health Mobilization, USPHS, outlined the recent policies promulgated concerning the storage of expendable medical supplies for a 30-day period in community hospitals. These supplies are to be used on a rotating basis with the hospital's own supplies. This program has already been initiated.

The following recommendations have been made by the Committee and approved by the Board of Trustees:

1) That signs directing to hospitals be placed on highways. These signs should be located at specific intervals on all toll roads in New Jersey and at toll booths and exits.

2) That a standard textbook be adopted for the training of physicians in emergency care and disaster situations, such as *The Nato Handbook on Emergency War Surgery* or *Fractures and Soft Tissue Injuries* by the American College of Surgeons.

3) That emergency telephone service be established on highways in New Jersey.

4) That a model "ordinance for ambulance service," as recommended by the American College of Surgeons and the National Safety Council, be supported for enactment by the State of New Jersey.

5) That the responsibility for the training of ambulance attendants be assumed by the component medical societies of The Medical Society of New Jersey.

The chairman of this Committee is a member of the State Emergency Medical and Health Resources Task Group and has assisted in the development of the Emergency Medical and Health Resources Plan, which has just completed its seventh and final revision for submission to the Governor and to the U.S. Office of Emergency Planning.

Approved (page 416)

Medicine and Religion

Jerome G. Kaufman, M.D., Chairman, Maplewood
(Reference Committee "D")

As was set forth in this Committee's 1966 annual report, the continuing role of the Committee on Medicine and Religion of MSNJ is to stimulate and encourage activities at local levels, where, exclusively, patient problems are found and dealt with. All but a few of our component societies have organized county committees, and activities within New Jersey's hospitals are showing heartening increase.

In the course of the year, the Committee met with Mr. Arne Larson, Assistant Director of the Department of Medicine and Religion of the AMA, and with him we participated in the discussions of the Fall meeting of the Conference of Presidents of Component Societies. In these sessions, we stressed our conviction that Medicine and Religion, working together, should not only work to prepare the moribund patient to die in a spirit of resignation and peace, but should strive to help patients so to live as to enjoy that full harmony of health, which embraces physical, mental, emotional, and spiritual balances, and makes for full and healthful living.

It is a pleasure to report that at a national meeting of Chairmen of State Society Committees on Medicine and Health, in Chicago in March, these emphases were reflected and discussions took place concerning potential effectiveness of cooperative endeavors on the part of Medicine and Religion in the treatment and control of conditions such as alcoholism, drug addiction, venereal disease, and traffic and industrial safety.

Approved (page 407)

Nursing Education and Recruitment

Jesse McCall, M.D., Chairman, Newton
(Reference Committee "H")

In this Committee's report to the House in 1965, it was pointed out that, through the initiative of MSNJ, exercised on the recommendation of this Committee, a Joint Committee on Nursing Education and Recruitment had been organized, composed of representatives of our Society and of the New Jersey Hospital Association, the New Jersey State Nurses' Association, the New Jersey Board of Nursing, the New Jersey League for Nursing, and the New Jersey State Department of Education. The Joint Committee, after a series of meetings, soon concluded that the solution of New Jersey's nurse shortage problem could not be met by the efforts and resources of the professions alone, but that financial assistance from government — at federal and state levels — was indispensable.

The Governor was so informed, and he responded by calling upon the Commissioner of Health, early in 1965, to set up the "Governor's Task Force on Nursing," to coordinate the State's efforts, together with the health, educational, and hospital professions in effecting short and long-term planning to increase the number of nurses in New Jersey. MSNJ's representatives on the Task Force have been and are Drs. Jesse McCall and William Mulford and Mr. Richard I. Nevin.

As was reported in 1966, the activity of this Committee centers about its participation, through its designated representatives in the work of the Task Force. In consequence of the work of the Task Force, the following can be cited as indicative of its accomplishments:

1) Inclusion, by legal enactment in 1965, of schools of professional nursing within the category of accredited colleges eligible for state scholarships.

2) Introduction and support of measures in the 1967 Legislature as follows:

A-189—To crease from $500 to $600 per year the amount of state competitive scholarships to institutions of higher learning.

S-409—To provide state aid to qualified schools of professional nursing.

3) Through a federal grant obtained under the Manpower and Development Act, conduct of refresher courses for nurses to facilitate their return to active duty was made possible. This program was initiated in July of 1965. As of the time of the compilation of this report, the New Jersey Hospital Association reports that 64 hospitals have participated and have presented 73 programs, in consequence of which approximately 400 nurses have returned to active nursing. Refresher courses run for 6 to 7 weeks and are given 5 days a week.

4) As of the beginning of 1967, 12 county (community) colleges have been approved by the State. Four have opened, and of these colleges three have started nursing programs and the fourth is planning to inaugurate a nursing program in the near future. Seventeen counties were studied as to their interest in community colleges and nursing, and all indicated an interest in nursing programs. The chief issue in developing new programs seems to be lack of prepared faculty.

Thus, the Society's interest and efforts concerning education and recruitment are being served and furthered, with some gratifying results to date and more to be expected in the future.

Approved (page 416)

Retirement Plan for Physicians

Nicholas E. Marchione, M.D., Chairman, Vineland
(Reference Committee "D")

During the past year, renewed interest has been generated in retirement plans for self-employed individuals and their employees as a result of HR-10, a bill which doubles tax deduction benefits of the Self-Employed Individuals Tax Retirement Act of 1962 (Keogh Act, P.L. 89-809.

Effective January 1, 1968, the maximum tax deductible contribution to retirement plans, which is taken from the top of your income before computing taxes, will be increased from $1250.00 to $2500.00, or ten percent of gross annual income, whichever is less.

HR-10 provides that contributions made on behalf of employees are fully tax-deductible. If a wife is employed by her husband, contributions to the plan may be made for her and these contributions are also fully deductible as a business expense. Other tax-sheltered advantages may be obtained by setting up a voluntary contribution plan for the employer and his employees in addition to the basic contribution.

During the past year, the Committee has received and scrutinized several plans. One of these was a Group Pension Plan drawn up by the Prudential Insurance Company. This is in the form of a variable annuity. A variable annuity is a device of liquidating a common stock investment portfolio over a period of time which is guaranteed to coincide with one's lifetime. In New Jersey, the Prudential Group Pension Plan is being offered by E. & W. Blanksteen Agency, Inc.

In addition to the above plan, another program offered for consideration was the Professional Retirement Organization called P.R.O., Inc., headed by Jim Castle. This group sponsors a Keogh Plan which is mainly a mutual fund investment plan in conjunction with life insurance and annuities or a combination of the three, tailored to suit individual requirements. This group maintains that it has a State Master Plan which has already been accepted by a number of component medical societies.

Another plan actively supported in the State is the plan of the MONY Associates.

Various specialty societies also offer Keogh Plans to their membership, one of the most active being the Jones Plan of the AAGP. The AMA sponsors a national plan available to the membership at large.

These, in summary, are the plans which have been reviewed by the Committee on Retirement Plan for Physicians.

In March the chairman of this Committee requested the opinion of the Board of Trustees as to whether or not the Committee should pursue investigation of a plan that would be set up and administered by The Medical Society of New Jersey. It was the opinion of the Board that the Society is not interested in a state-sponsored plan, since so many members are satisfied on an individual basis with plans already in existence. The Board did direct that this opinion be disseminated to the component societies.

It is the opinion of this Committee that it would be judicious for each individual member to seek financial advice from someone well versed in overall financial management of income. With so many retirement plans available, members can be directed to a plan tailor-made to their needs.

Since more liberal deductible annuities are allowed and since all earnings on contributions are tax deferred until the time one receives his benefits (when he will probably be in a lower tax bracket), the Committee is of the opinion that it behooves each physician-member to review his position carefully and to decide whether or not the Keogh Plan at this time might be more beneficial.

With this in view, the Committee on Retirement Plan for Physicians requests the continuation of this Special Committee so that it may continue to explore retirement plans and keep the membership of the Society informed of changes and innovations as they may arise in the future.

Approved (page 408)

Traffic Safety

William L. Sprout, M.D., Chairman, Salem
(Reference Committee "H")



Upon referral from the Council on Legislation, the Committee studied Assembly Bill 292 — to provide for physical fitness re-examination of motor vehicle licensees at least once every three years. Present for discussion of this measure was a representative from the Division of Motor Vehicles.

In discussing this proposed legislation, the Committee's attention was directed to the 1964 annual report of the Committee on Traffic Safety, which was approved by the House. The Committee at that time recommended — and the House approved — policy statements opposing compulsory physical examinations for issuance of driver's licenses, on the basis of a position adopted by the AMA (1963) House of Delegates. The statement adopted by the AMA House pointed out that (at that time) there were some 91 million licensed drivers in the United States, and commented that "to give medical examinations initially and periodically to this number for the purpose of licensing to operate a motor vehicle is to use medical manpower with less than optimum effectiveness." The AMA urged physicians to assume leadership in the development of sound medical criteria for licensing, and recommended that a medical examination for "driver limitation" be conducted under these conditions:

1) When an applicant displays an obviously impaired physical function.

2) When a driver has been involved in several accidents within a short period of time.

3) When a driver has been placed in the "assigned risk" pool for insurance because of refusal by commercial insurance carriers to assume the risk.

4) When a driver voluntarily suggests that he "blacked out" or that medical problems contributed to an accident.

As the most significant medical problems which must be evaluated in determining "driver limitation" the report listed mental retardation, uncompensated deformities, neurological defects, cardiovascular defects, psychiatric problems, gross sensory defects, chronic alcoholism, and drug addiction.

It was generally noted by all present at the Committee meeting that:

1) Assembly Bill 292 was not sponsored — or even supported — by the Division of Motor Vehicles or the Administration.

2) The bill as drawn is unclear as to its exact and specific intent. If it requires a detailed, complete physical examination by a licensed physician, it would impose an unreasonable and impossible burden which the medical profession could not bear, because with approximately 3½ million drivers in New Jersey at the present time, it would mean almost 1 million examination a year. If the measure means anything other than a detailed examination, the procedure might well prove to be a waste of time and money. It was therefore agreed that it would be desirable to write to the sponsors of the measure and ascertain from them their intent in sponsoring this legislation. Meanwhile, the Committee unanimously recommended that A-292 be disapproved, as unclear as to its intent and impractical in terms of fulfillment.

It was generally agreed among those present that — although the principle of physical fitness to operate a motor vehicle is a sound and proper one — it is difficult to establish specific standards adequately to implement legislation. It was also generally agreed that an advisory panel of physicians to the Division — similar to those established for cardiac and convulsive seizure cases — might be of value in determining who, how, and for what the suspended licensees should be evaluated.

The group concluded that some method should be devised that would detect and debar from the road an individual who is no longer capable of driving a car safely because he is not physically fit.

Representatives of MSNJ suggested that the Division of Motor Vehicles refer to MSNJ the rules and regulations governing driver re-examination at the present time, so that this Committee might evaluate the tests given. Through study and discussion, the Committee might devise some tangible and realistic approach to the problem.

The Committee informally offered itself as willing and eager to serve as an advisory committee to the Division to assist in these areas, if the Division were to so request the Society. If necessary, the Committee could, in such capacity, call upon members of specialty societies to assist in evolving sound plans and procedures.

Federal Standards For Highway Safety

In connection with the foregoing discussion, reference was made to an initial set of traffic standards for state and local highways safety programs released under date of February 16, 1967 by the United States Department of Commerce. The draft standards were submitted for comment and suggestions to representatives of the Governors of the 50 states who met in Washington to discuss implementation of the Highway Safety Act of 1966. Under the provisions of this act, the Secretary of Commerce is to develop the standards "in cooperation with the states, their political subdivisions, appropriate federal departments and agencies, and such other private and political organizations as the Secretary deems appropriate." All drafts are based on current practices, studies of previous research, and the suggestions of many individuals and organizations. The Highway Safety Act requires every state to be implementing a program approved by the Secretary by December 31, 1968.

In reviewing the standards for driver licensing proposed, the Committee noted that stipulation is made in the federal standards for periodical re-examination of every licensed driver at least once every four years. The Committee reviewed the criteria of the examination and concluded that other approaches should be discussed before consideration is given to approval of the federal standards, as proposed.

Approved (page 417)

Medical-Surgical Plan of New Jersey

Nicholas F. Alfano, M.D., President, Newark
(Reference Committee "C")



As Medical-Surgical Plan rounds out its first quarter-century of service, the times call for sober reflection of our position today, together with grave consideration of our role in the future, by the Plan and Society alike. The tide of events is carrying us swiftly, in some instances down courses that we may not have chosen, but are powerless to dictate. How effectively we are able, jointly, to steer the most advantageous course can have a crucial bearing on the continued existence of the free enterprise system of medical practice in New Jersey, and of Blue Shield as the profession's arm in implementing that philosophy.

Nothing can be gained by deploring past circumstances that have brought us to where we are; much can be gained by united effort in helping shape, insofar as we are able, the circumstances of today and tomorrow, and thus preserving some measure of choice and control.

Perhaps it has happened for the best that the grave financial crisis which Blue Shield has been undergoing occurs at a time when concepts of health care coverages — scope of benefits, basis of allowances, and similar fundamentals — are undergoing widespread reappraisal and drastic revision. While this has received its most recent and major impetus from the advent of govenment programs, a similar revolution had been growing in the private sector for the past few years, which inevitably will now gather added strength and speed.

Until quite recently, Medical-Surgical Plan has not, for one reason or another, been in step with this trend. The first major breakthrough occurred just a year ago when the House of Delegates approved the Plan's offering a special contract, with liberalized service benefits and an augmented fee schedule, to experience-rated national account contracts. This enabled the Plan to retain about 100,000 members associated with the automobile industry, who otherwise would have transferred to another carrier; it also makes possible retaining or gaining other accounts demanding like coverage.

The same prospect — provide the type of coverage demanded, or lose the enrollment — faces Medical-Surgical Plan again this year. If we cannot deliver a Prevailing Fee program by August 1, the steel industry's over 20,000 Plan members will transfer to another carrier. If we do deliver it, we will not only retain those members but also stand to add a sizeable number of New Jersey steel employees currently enrolled with another carrier.

And so it will continue to go: Special programs with wider scope of physicians' services, higher income limits, no income limits at all — coverage of paramedical services, drugs, appliances — all will be incorporated in the non-profit private sector, as they already have been by the government. And incidentally, Medical-Surgical Plan already is paying for all of those, as carrier for the Civilian Health and Medical Program of the Uniformed Services.

The big point is that up to now we have been getting aboard programs like Motors and Steel at the eleventh hour, in a sort of desparation measure. Unless we are ready, willing and able to assume the initiative to keep the non-profit private sector in the forefront of considerations of labor and management, by having available what they ask, and developing new offerings to introduce to them, we are surely going to see the areas that are not covered by broad government programs pass into the hands of carriers without any ties or responsibilities to organized medicine, with-

out adequate professional representation on their governing bodies, and without the patient getting the kind of return on his premium dollar, in benefits, that Blue Shield assures him.

How does all this relate directly to the Plan's present financial straits? In several ways.

There are some directions in which we can move, with the active backing of organized medicine, that would improve the Plan's overall condition by easing the stress from those areas in which we are circumscribed.

To put it another way, it is obvious that Prevailing Fee or other similar special programs can never replace completely the basic Blue Shield concept of providing essential coverage for persons of modest financial resources. This was the original intent of organized medicine, and we assume that it still is.

However, if Blue Shield must, at best, eke out a marginal existence under minimal rates for its basic program, or at worst lose money on that program, the broader and more diversified — and more expensive — types of programs can continue to gain. The more of these self-sustaining programs the Plan can provide, the less the impact of drain from other quarters.

In this regard, the Society can help preserve the Plan — and its role as a vehicle for the free enterprise medical system — by working with us to approve the available tools, and to forge new ones, that will produce the flexibility Blue Shield needs to meet these special account requirements.

There are other battles which we must — and I am sure will — fight together. To further assure the continued availability of its basic protection, the Plan must be granted the authority for limited experience-rating of local accounts. This is a matter requiring legislation, and we earnestly solicit the active partnership of the Society in working toward obtaining it.

We must continue to stand together in resisting legislative attempts to place the determination of fees in unqualified hands, or to force the Plan by legislation to cover services other than those of its own election, or to impose such heavy financial responsibilities upon the Plan when it seeks rate relief that a small rate increase would scarcely counterbalance the costs entailed in obtaining it. We must bend our joint efforts toward seeing that the just needs of the Plan are adequately met, and not shrugged off as being inspired by "money-grubbing" physicians in their own interest.

We are, of course, aware that some physicians are of the opinion that Blue Shield has outlived its usefulness — that the depression-born needs which created the Plan no longer obtain. For some, it has already grown too complex in its coverages, too time-consuming in the paperwork required, too inadequate in its allowances under today's economy. Who needs it?

Very frankly, I think that organized medicine does. And I think that the great majority of the profession, upon sober reflection, will agree.

We doctors are noted for being individualists, and medicine would be the loser were we not. The Plan respects the right of any physician to disagree with its policies, complain about its payments, or criticize its service. As hard as we try, we are far from perfect, as we know from reading our mail. On the other hand, a bare handful of physicians bother to attend the Open Discussion on Medical-Surgical Plan, where the basics of what Medical-Surgical is, and where it is going, are open to forum discussion.

This year, there will be no general opening remarks by the President at the Open Discussion. I have attempted to cover, in this message, the points that need to be made. I only ask, and strongly urge, that enough members of the Society attend and take an active part in this year's Open Discussion, so that we may together carve out the joint role of Medical-Surgical Plan and The Medical Society of New Jersey for the future.

Otherwise, the Blue Shield instrumentality may be lost to organized medicine – and with it some of the most cherished fundamentals of medical practice in New Jersey. We do not believe that the physicians of New Jersey will allow this to happen.

Comparative Balance Sheet December 31, 1966

Assets	*1966*	*1965*
Cash on Hand and in Banks (Working Funds)	$ 1,316,031	$ 221,999
Investments	12,305,413	15,082,780
Accounts Receivable:		
Subscriptions	1,520,295	820,637
Workmen's Compensation	2,780	30,605
Federal Employee Program	531,528	531,663
Other	342,069	298,783
Accrued Interest and Dividends Receivable	122,547	166,368
Total Assets	$16,140,663	$17,152,835
Liabilities		
Claims Outstanding:		
Reported $2,311,000	$1,742,000	
Unreported 8,466,000	8,770,000	
National Accounts 139,000	$10,916,000 76,000	$10,588,000
Unearned Subscriptions	2,535,915	2,521,430
Accounts Payable—		
Hospital Service Plan	569,901	
Miscellaneous	1,257,260	389,787
Total Liabilities	$15,279,076	$13,499,217
Reserves		
Securities Evaluation	$ 370,200	$ 452,000
Special Contingent	100,000	100,000
Unassigned	391,387	3,101,618
Total Reserves	$ 861,587	$ 3,653,618
Total Liabilities and Reserves	$16,140,663	$17,152,835

Annual Statistics—1966

TABLE I

Paid 1966	*Total Services*	*% All Services*	*Payment*	*Percent*	*Payment Per Service*
Surgical	441,844	42.0%	$25,658,674	50.0%	$ 58.07
Medical	366,360	34.8	14,420,174	28.1	39.36
Obstetrical	45,194	4.3	6,312,033	12.3	139.67
Consultations	56,841	5.4	1,128,981	2.2	19.86
Anesthesia	141,504	13.5	3,797,484	7.4	26.84
Total	1,051,743	100.0%	$51,317,346	100.0%	$ 48.79

TABLE II

Distribution of Rider Services and Payment

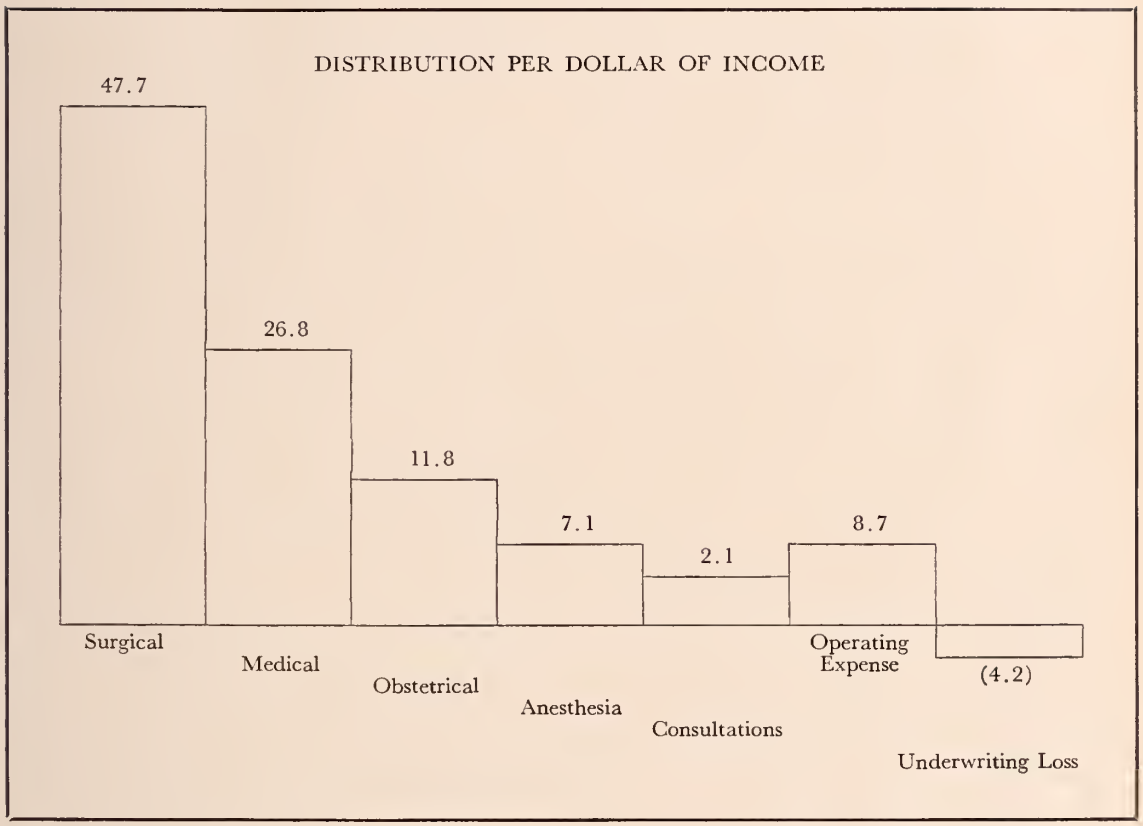
	Total Services	*% All Services*	*Payment Amount*	*Payment Percent*	*Payment Per Service*
Surgical	31,188	15.6%	$ 641,515	16.0%	$ 20.57
Medical	6,041	3.0	318,984	8.0	52.80
Diagnostic X-ray	79,916	39.8	1,743,540	43.6	21.82
X-ray Therapy	866	0.4	130,621	3.3	150.83
Physical Therapy	6,910	3.4	184,554	4.6	26.71
Pathology	75,885	37.8	979,439	24.5	12.91
Total	200,806	100.0%	$ 3,998,653	100.0%	$ 19.91

Excludes Federal Claims Data.

TABLE III

Distribution of Earned Subscription Income

Earned Subscription Income	$56,029,816	100.0%
Incurred Claims	53,523,540	95.5
Operating Expense	4,852,929	8.7
Underwriting (Loss)	2,346,653	(4.2)



FEDERAL EMPLOYEE PROGRAM

Following is a statement of income and expense, along with utilization statistics of the 1966 experience of the Federal Employee Program.

Income	$1,993,958	100.00%
Claims Incurred	1,847,194*	92.64
	146,764	7.36
Operating Expense	113,830	5.71
Gain	32,934	1.65%

Paid Basis

Average Exposure (Persons)	113,393
Claim Incidence per 1,000 Persons Enrolled	207
Average Cost Per Case	$79.93
Number of Cases	23,499
Amount Paid	$1,878,194*

*NOTE: Despite their similarity, these figures represent different categories: Claims Incurred include claims for 1966 services that were not paid until after 1966; Amount Paid represents actual disbursements made in 1966, including those for services rendered prior to 1966.

PUBLIC RELATIONS PROGRAM

A review of the events of 1966 (and early 1967) indicates that, despite a certain amount of trauma and frustration, they were not without their positive Public Relations aspects.

This is not to say that the Plan's popularity was generally enhanced by its need to increase rates, which was the most crucial public relations issue to arise. There is no magic formula, public relations-wise or otherwise, to make people happy about any cost increase — even when it amounts to only pennies and for something as vital as medical-surgical cost protection. In such circumstances the public relations goal must be to attain the highest possible degree of public understanding and acceptance for the pill that must be swallowed.

This, of course, is not an overnight project. For more than a year groundwork had been laid through various avenues aimed at making the public aware that the Plan's benefits — but not its rates — had been increased since 1961, and that its scale of allowances, prior to 1965, was outdated and was brought to no more than a reasonable level by the 1965 adjustments. There were reminders that additional liability had been created by legislative fiat, without additional premium to support it.

The "conditioning" process sharpened its focus late last Summer with a concentrated campaign of radio testimonials, based on the well-established premise that while no one really appreciates his coverage until he has to use it, those who have had to do so can, and will, tell how valuable it proved.

When the rate filing was announced, stress was placed upon the fact that this was the first Blue Shield increase sought in six years, and for protection that was one of the greatest bargains in today's economy.

Apart from perennial critics who automatically react adversely, there was apparent a broader understanding and acceptance than is characteristic of such situations.

The Plan's side of the story — the justification of its needs — was accorded full and fair treatment by the news media, almost verging upon the sympathetic in some instances. This was particularly true of the treatment accorded the very convincing case so ably presented at the public hearing, for which public relations can claim credit only for helping fashion some of the framework.

One of the more important public relations aspects that emerged was the apparent increased public awareness of Blue Shield's separate identity and functions. Since its establishment six years ago the Public Relations Office has been charged with the responsibility of working toward achieving such awareness.

Another plus was the Plan's effective rebuttal of attempts to blame its financial condition on higher fees "voted themselves by doctors." The Plan acted quickly to set the true facts before the public, and reaffirm its intention not to unjustly penalize its Participating Doctors by cutting back fees to a 1958 level.

In summary, we believe that the Plan today may well be better understood, accepted, and respected than it was before 1966.

Claims Incurred

Year	Amount
1966	$53,524,000
1963	40,991,000
1960	31,516,000
1957	22,886,000
1954	13,992,000
1951	6,527,000
1948	1,204,000
1945	208,000
1942	5,000

Incidence Rate (Cases) Per 1,000 Persons Enrolled

Year	Incidence
1966	266
1963	193
1960	166
1957	143
1954	126
1951	112
1948	96
1945	86
1942	40

Physician Relations Program

During 1966, the Physician Relations Section maintained its objective of liaison and cooperation between the Plan and its thousands of Participating Doctors.

This objective was accomplished through many avenues of communication, including: maintenance of information desks in the physician's lounge of thirty-six hospitals; addressing physicians at medical staff meetings in fifteen hospitals; personal visits to the offices of one hundred and one physicians; manning Plan exhibits at several medical conventions; and attendance at many other miscellaneous meetings, including those of county medical societies, specialty societies and medical assistants.

The primary purpose of this field program is to explain Plan policy; advise physicians of such matters as changes in the Schedule of Maximum Plan Payments, issuance of new contracts and riders with broader benefits, and

manner of payment for specific services; and to resolve any problems the physician and/or his medical assistant is encountering in his dealings with the Plan.

In the Plan's office, the Physicians Relations Section performed many additional duties contributing to effective communications between the Plan and its Participating Doctors. Hundreds of problem cases involving physicians and subscribers were resolved, in the course of which thousands of telephone calls and hundreds of written communications were handled. The Section also prepared, proofread and distributed fee schedule revisions, the 575-M Schedule of Payments, and Newsletters to physicians. The Section also maintained the physician status files, making daily additions, deletions, address changes, participating status, etc., and prepared and proofread the listings of Participating Doctors distributed to thousands of subscribers throughout the State.

It is our belief that each facet of this program has effectively maintained and strengthened relationship of Blue Shield with the medical profession. Our task has been made easier by the genuine interest and cooperation shown by individual physicians during the course of the many thousands of personal contacts made during the past year.

We are "selling" an intangible item . . . good will. Since our contacts are to a large degree personal, the results can only be measured by our individual perception of greater warmth, cooperation, and reliance upon our services by the medical profession.

In the coming year, every effort will be made to effectively maintain and enhance this "two way" street of communication between the Plan and the medical profession.

Civilian Health and Medical Program of the Uniformed Services

Medical-Surgical Plan experienced its second full year of fiscal administration of payments to physicians under the government's CHAMPUS.

As of July 1, 1966 Contract #DADA-04-67-c-0011 was executed by the President on behalf of the Trustees of Medical-Surgical Plan of New Jersey, as was a bond in support of an advance of $95,000.

Statistical Data

Following is the claim experience for 1966.

CLAIMS

Received	*Declined*	*Returned Incomplete*
10,039	308	3,454

Paid		
Claims	*Amount*	*On Hand*
6,221	$483,308	452

City of Newark Medical Plan

Effective June 1, 1965, Medical-Surgical Plan of New Jersey assumed the administrative functions of the City of Newark Medical Plan on behalf of Medical Service Administration of New Jersey.

Approved services rendered from January 1, to December 31, 1966, as compared with former years, were:

RELIEF

Year	*Number of Cases*	*Value of Services*
1960	1654	$7,417
1961	1484	$6,914
1962	1151	$5,329
1963	1149	$5,339
1964	1146	$5,736.50
1965	1128	$6,287.50
1966	682	$3,770

MEDICALLY INDIGENT

Year	*Number of Cases*	*Value of Services*
1960	2553	$11,979
1961	1732	$ 8,197
1962	1252	$ 5,999
1963	1189	$ 5,587
1964	862	$ 4,420
1965	962	$ 5,585
1966	931	$ 5,395

Enrollment Report

Medical-Surgical Plan's net growth in 1966, highest to date in the "sixties," totaled 134,750 persons as a result of the 97,620 contracts enrolled during the year. Plan enrollment of 1,149,000 subscribers, representing a membership total of 2,779,097 persons, ranks fifth largest among the nation's Blue Shield Plans. With the introduction of programs to complement Medicare in July 1966 changes in the

structure of our enrollment occurred. Within group categories of enrollment, over 67,800 members, aged 65 and over, were transferred from basic or basic-and-rider coverage into one of the several Medicare complementary programs designed for these aged members. Within the Direct Payment categories a net total of 110,782 members were added to the rolls of this new coverage as the result of the transfer of existing members and new members enrolled during the open enrollment period.

Group lines of business recorded a net increase of 31,232 contracts (78,219 members) resulting from gains in Rider J, and in the National Account area of enrollment. Rider J coverage still is exhibiting strong market appeal. As of year end 1966 over three-quarters of a million group members were covered by this extended benefits rider and in 1966 a total net growth of 53,000 contracts was experienced. Basic-only coverage continued its decline as the trend toward a broader scope of benefits under rider programs and national account contracts became more accentuated.

Within the Direct Payment lines a net increase in exposure of 66,368 contracts is reported. Due to the sizeable exposure of over age 65 members in the Direct Payment lines, this category of business suffered a net loss from basic coverage of 118,632 members, many of whom transferred to the new "Blue Cross and Blue Shield 65" Medicare complementary program. Student enrollment displayed a net gain of 4,646 contracts, and, following trends of other lines of coverages, many of these subscribers selected Rider J coverage to supplement their basic benefits program.

The introduction in 1966 of a higher income limit and fee schedule for the nationally rated auto accounts is indicative of developments that will continue to be reflected in market demands during 1967. For example, the nationally negotiated Steel Contract specifies Medical-Surgical benefits to be provided on a Prevailing Fee basis as of August 1, 1967. Overall, current labor negotiations point toward a continuing extension of existing benefits in the health care field, with an increasing need for flexibility on the part of Blue Shield to provide the benefits sought.

ENROLLMENT GROWTH

Year	Enrollment
1966	2,779,097
1963	2,450,755
1960	2,080,582
1967	1,711,834
1954	1,196,804
1951	669,906
1945	236,604
1942	4,131

COMPARATIVE SUMMARY OF OPERATIONS

	1966			1965	
Subscriptions Earned*	$56,029,816	100.0%		$52,416,367	100.0%
Less:					
Claims Incurred...$53,523,540**		95.5	$49,505,321		94.5
Operating Expenses 4,852,929***		95.5	$49,505,321		94.5
Operating Expenses 4,852,929***		8.7	4,524,355		8.6
	58,376,469	104.2%		54,029,676	103.1%
(Loss) from Underwriting Operations	(2,346,653)	4.2%		(1,613,309)	3.1%
Income on Investments	334,870			544,059	
Operating (Loss) for the Year	($ 2,011,783)			($ 1,069,250)	

* The gain of $3,613,449 in subscriptions earned reflects gains in enrollment, which increased by 134,750 during the yrar.

** The rise of $4,018,219 in claims incurred is attributable to increased exposure from larger enrollment and to increased incidence, which rose from 237 per 1,000 persons to 256.

*** The increase of $328,574 in operating expenses is caused by increased services rendered by Hospital Service Plan in the amount of $280,477 and a increase of ($48,097) in Medical-Surgical Plan direct expenses. Based on subscriptions earned, total operating expense increased by one tenth of one percent.

SUMMARY OF RESERVES FOR PROTECTION OF SUBSCRIBERS

		1966		1965
Reserves at January 1		$3,653,618		$5,075,237
Operating (Loss) for the Year		(2,011,783)		(1,069,250)
		1,641,835		4,005,987
Plus: Reserve Adjustments				
Non-Admitted Assets	($247,194)		($ 12,503)	
Unrealized Capital Gains	(210,484		139,434	
Claim Reserve			(450,000)	
Distribution of Prior Year's Income	174,814		(29,300)	
Group Contract Settlement	(497,384)	(780,248)		(352,369)
		$ 861,587*		$3,653,618

* The decrease of $2,792,031 in reserves for the protection of Plan Subscribers is caused by a net operating loss of $2,011,783 and reserve adjustments totaling $780,248.

OFFICERS

Thomas J. White, M.D.
Chairman of the Board

Nicholas F. Alfano, M.D.
President and Medical Director

John S. Robinson
Executive Vice President

William S. Skelley
Secretary-Treasurer

1966 BOARD OF TRUSTEES

Chairman of the Board
Thomas J. White, M.D. (1968)

First Vice President
Jerome G. Kaufman, M.D. (1967)

Second Vice President
Rudolph C. Schretzmann, M.D. (1968)

Edwin H. Albano, M.D. (1968)
George J. Bartel (1967
Robert G. Boyd (1969)
Joseph A. Cox, M.D. (1969)
Charles L. Cunniff, M.D. (1969)
Andrew P. Dedick, Jr., M.D. (1969)
Joseph P. Donnelly, M.D. (1967)
Edgar P. Eaton, Jr. (1967)
Joseph I. Echikson, M.D. (1967)
Lloyd M. Felmly (1968)
Edwin T. Ferren, D.O. (1967)
Paul M. Forbes (1969)

Mortimer J. Fox, Jr. (1967)
Joseph R. Jehl, M.D. (1967)
Joseph P. Keating, M.D. (1967)
Elton W. Lance, M.D. (1967)
Samuel J. Lloyd, M.D. (1967)
Theron L. Marsh (1968)
Jesse McCall, M.D. (1967)
Earl R. Mellen –1968)
Warren H. Simmons (1969)
Sidney I. Simon, Ph.D. (1969)
Charles O. Tyler, M.D. (1968)
Robert E. Verdon, M.D. (1969)

TRUSTEES EMERITUS

	Appointed	*Term as Board Member*
Edward W. Sprague, M.D.	1966	1942–1966
John S. Thompson	1966	1942–1965

ADVISORS TO THE BOARD OF TRUSTEES

	Appointed	*Term as Board Member*
F. Clyde Bowers, M.D.	1963	1961–1963
Harry N. Comando, M.D.	1959	1942–1958
William F. Costello, M.D.	1958	1948–1958
William E. Dodd, M.D.	1952	1944–1952

FORMER MEMBERS OF THE BOARD OF TRUSTEES

David B. Allman, M.D.
1945–1945
* Charles W. Barkhorn, M.D.
1952–1965
Irving P. Borsher, M.D.
1950–1965
Sigurd W. Johnsen, M.D.
1942–1948
* Augustus S. Knight, M.D.
1942–1948
* Thomas K. Lewis, M.D.
1942–1949
* Norman M. Scott, M.D.
1942–1950
Reuben L. Sharp, M.D.
1950–1951

* Deceased.

* Theophilus H. Boysen, M.D.
1944–1945
Lewis W. Brons, M.D.
1949–1954
* William J. Carrington, M.D.
1942–1943
* Samuel A. Cosgrove, M.D.
1944–1953
William K. Harryman, M.D.
1944–1945
* Arthur W. Lunn
1951–1962
Paul Mecray, Jr., M.D.
1953–1961
Duane E. Minard, Jr.
1957–1965
Glennis S. Rickert, M.D.
1959–1963
* Royal A. Schaaf, M.D.
1942–1964
James J. Spencer, M.D.
1957–1961
Gustave E. Wiedenmayer
1961–1966
* Carl K. Withers
1952–1961
David L. Yunich
1962–1963

N. J. PARTICIPATING AND NON-PARTICIPATING PHYSICIANS BY COUNTY

January 16, 1967

County	Total Eligible Phys.	Participating Total	Participating M.D.	Participating D.O.	Participating D.S.C.	Participating Lab.	Participating D.D.S.	Non-Participating Total	Non-Participating M.D.	Non-Participating D.O.	Non-Participating D.S.C.	Non-Participating Lab.	Non-Participating D.D.S.	% P. P. as of 12-31-66	% P. P. as of 12-31-65
1. Atlantic	237	217	172	18	15	7	5	20	19				1	91.5	93.0
2. Bergen	1111	656	527	57	30	15	27	455	413	16	5	1	20	59.0	60.7
3. Burlington	237	210	160	31	9	2	8	27	22	4			1	88.6	89.1
4. Camden	464	562	362	144	31	7	18	84	75	4	2		3	86.9	86.7
5. Cape May	70	66	49	10	3	2	2	4	1	3				94.2	91.7
6. Cumberland	125	118	99	5	6	4	4	7	4	1			2	94.4	96.0
7. Essex	1686	1340	1192	44	63	16	25	346	300	10	3	4	29	79.5	79.6
8. Gloucester	139	121	76	27	9	3	6	18	15	2			1	87.0	87.1
9. Hudson	725	593	519	12	37	6	19	132	122		2	2	6	81.7	80.3
10. Hunterdon	64	60	59				1	4	4					93.7	91.6
11. Mercer	498	400	359	14	15	5	7	98	86	4			8	80.3	80.5
12. Middlesex	455	347	302	14	16	10	5	108	91	1		2	14	76.2	76.4
13. Monmouth	476	344	297	17	14	4	12	132	119	3	1		9	72.2	73.5
14. Morris	436	348	296	22	9	8	13	88	70	2	3	1	12	79.8	81.7
15. Ocean	156	111	94	11	3	1	2	45	41	1			3	71.1	71.7
16. Passaic	643	463	390	27	29	5	12	180	160	3	2	1	14	72.0	73.9
17. Salem	56	53	42	5	2	1	3	3	2	1				94.6	94.2
18. Somerset	160	125	113	3	3	1	5	35	29	1	1	1	3	78.1	82.7
19. Sussex	56	51	40	4	1	1	5	5	5					91.0	92.1
20. Union	804	563	471	36	36	7	13	241	215	7	1	1	17	70.0	70.3
21. Warren	49	47	43	2		2		2	2					95.9	96.2
22. Out of State	325	292	255	30	4	2	1	33	33					89.8	91.8
TOTALS	9154	7087	5917	533	335	109	193	2067	1828	63	20	13	143	77.4	78.1

N. J. PARTICIPATING AND NON-PARTICIPATING PHYSICIANS BY SPECIALTY

Specialty	Total Eligible Phys.	Participating Total	Participating M.D.	Participating D.O.	Participating D.S.C.	Participating Lab.	Participating D.D.S.	Non-Participating Total	Non-Participating M.D.	Non-Participating D.O.	Non-Participating D.S.C.	Non-Participating Lab.	Non-Participating D.D.S.	% P. P. as of 12-31-66	% P. P. as of 12-31-65
1. Anes	372	191	180	11				181	178	3				51.3	52.4
2. Derm.-Syph.	133	104	104					29	29					78.2	80.7
3. Int. Med.	1115	847	833	14				268	267	1				75.9	76.9
4. Neur. Surg.	47	18	18					29	29					38.3	46.3
5. Obst.-Gyn.	616	314	309	5				302	300	2				50.9	49.4
6. Ophth.	281	181	179	2				100	99	1				64.4	65.3
7. Orth. Surg.	228	139	136	3				89	89					60.9	63.1
8. Otol.	157	99	97	2				58	58					63.0	59.7
9. Path.	134	109	107	2				25	24	1				81.3	80.8
10. Ped.	464	419	418	1				45	45					90.3	90.8
11. Phys. Med.	14	10	10					4	4					71.4	73.3
12. Plast. Surg.	27	8	7	1				19	19					29.6	26.9
13. Analy. Labs.	122	109				109		13				13		89.3	89.8
14. Proct.	32	20	15	5				12	12					62.5	68.7
15. Psy. & Neuro.	290	205	203	2				85	85					70.6	72.6
16. Radiology	209	156	150	6				53	53					74.6	77.4
17. Surg.	743	549	537	12				194	191	3				73.8	74.6
18. Thor. Surg.	19	11	11					8	8					57.8	52.9
19. Urol.	164	97	95	2				67	67					59.1	58.4
20. Chiropody	355	335			335			20			20			94.3	93.5
21. General	3296	2973	2508	465				323	271	52				90.2	89.8
22. Dentists	336	193					193	143					143	57.4	59.8
TOTALS	9154	7087	5917	533	335	109	193	2067	1828	63	20	13	143	77.4	78.1

*Deceased.

Approved (page 405)

Supplemental Report

1. Prevailing Fee Program

The Medical-Surgical Plan Board of Trustees studied for many months the matter of making available a Prevailing Fee Program, not based on income limits, to experience-rated national accounts requesting this type of coverage. In connection with this, the Plan recently undertook a survey of all New Jersey doctors as to their usual charges, which included an explanation of the Prevailing Fee concept and mechanism (Exhibit).*

The Board of Trustees has authorized the Plan to institute a Prevailing Fee Program for experience-rated national accounts, and to submit a Supplemental Report thereon for approval by the House of Delegates of The Medical Society of New Jersey. The Board's action was based upon the conviction that a Prevailing Fee Program will enable the Plan to:

Offer flexibility in Blue Shield coverage that would serve the best interests of subscribers and Participating Physicians, while keeping the Plan in step with the trend in health care protection.

Retain present large national accounts, and gain new ones, whose enrollment is vital to the maintenance of the Plan's protection of lower income subscribers under its basic coverage.

Participate in an effective Blue Shield national account mechanism that is gaining increasing acceptance throughout the country.

Recommendation

The Trustees of Medical-Surgical Plan of New Jersey therefore recommend that the Trustees and House of Delegates of The Medical Society of New Jersey approve provision by the Plan of a Prevailing Fee Program for those experience-rated national accounts which desire such a program.

Approved, with the suggestion that this entire situation be reviewed by the House at the 1968 annual meeting for the purpose of critical evaluation in the light of the year's experience. (page 406)

2. Rider Covering Out-of-hospital Services Under "Blue Cross and Blue Shield 65" Program

With the advent of Medicare, Medical-Surgical Plan together with Hospital Service Plan of New Jersey introduced, for persons aged 65 and over, programs complementing the benefits available under Medicare Parts A and B. The "Blue Cross and Blue Shield 65" Program provides for payment by Blue Shield of the beneficiary's $50 deductible and 20% co-insurance required by Medicare Part B, for eligible services rendered in-hospital only. Direct Payment subscribers aged 65 and over were converted to this program with the inception of Medicare, and a few enrolled Groups selected this type of Medicare complementary coverage over the other type available to them, known as "carve-out." New Direct Payment subscribers aged 65 and over also are accepted for the "65" Program.

From the outset, there has been dissatisfaction with the program's coverage, arising from two sources. Many subscribers who had previously held Rider J coverage for services outside of hospital wished to continue enjoying that type of extended benefits coverage, which, however, it was not financially feasible to the Plan to include in the "65" Program under the premium of $4.50 per month, or $13.50 a quarter, being charged. Some physicians also objected to the coverage being limited to in-hospital services.

After considerable study the Board of Trustees voted to offer an extended benefits Rider to subscribers under the "65" Program, at additional premium, to cover Medicare's $50 deductible and 20% co-insurance requirements, for the following physicians' services rendered outside of hospital: Diagnostic x-ray and/or radioactive isotope studies; pathological laboratory work; diagnostic surgical services; surgery for accidental injury and cutting or cauterizing surgery for non-accidental conditions; physical therapy; therapeutic x-ray treatments for proven malignancy and/or radioactive isotope treatments.

Recommendation

The Trustees of Medical-Surgical Plan therefore recommend that the Trustees and House of Delegates of The Medical Society of New Jersey approve the offering by the Plan, to

subscribers enrolled under the "Blue Cross and Blue Shield 65" Program, of an Extended Benefits Rider providing benefits for the services described above, when rendered outside of a hospital.

Approved (page 406)

* Exhibit

Dear Doctor:

The Plan in its recent communication, copy attached, informed you of its forthcoming survey and the underlying reason making such survey essential at this time.

The material forwarded represents two parts of that survey:

1. A pre-printed section for Medical Services which, to a greater or lesser extent, involves all physicians.

2. On the reverse, a computer-printed list of surgical procedures for which the Plan has been billed by you during the first nine months of 1966.

The surgical procedures are printed in descending order of frequency and with the exception of procedures not subject to a set fee, should constitute a fairly complete profile of your surgical practice. The description of each procedure has been abbreviated to meet space requirements; if the abbreviation is not clear, please consult the Plan's Fee Schedule under the appropriate code number.

If you have billed the Plan for more than nine laboratory, x-ray, or anesthesia services during the first nine months of 1966, you should receive within one week additional separate questionnaires for those categories, as applicable. A separate mailing will be made to Psychiatrists of whom the Plan has records.

If any physician fails to receive a supplementary survey required for his type of practice, it may be obtained by calling our Physician Relation Section—662-2201 (area code 201.)

The fee to be entered for each service you customarily perform should be your usual charge to most of your patients for that service without consideration of insurance (Blue Shield or commercial), or any other non-medical factor. The phrase "most of your patients" is used in order to eliminate both economic extremes, the indigent and the extremely affluent.

In the Surgical Section, this fee should include payment for the usual post-operative surgical care required following discharge from the hospital, or following office surgery. (Laboratory, X-ray and Physical Medicine charges not to be included in Surgical Fee) Please enter a single fee, your usual fee, not a range, for each service. A range is not workable and also unnecessary. The Prevailing Fee Program is flexible enough to permit payment in excess of a physician's "usual fee" when an unusual situation occurs.

Several items on this survey are not covered by any of the Plan's current programs. Fees are requested for such services at this time since they are ratable and therefore insurable, if a purchaser desires to pay the premium. With the rapid growth of health insurance, some or all of these services may be included in Blue Shield programs in the very near future.

The completion of this survey in no way binds you or the Plan in any manner. The Plan will develop and market a Prevailing Fee Program if, (a) sufficient replies are received, (b) our actuaries find it to be feasible, and (c) it is approved by the Plan's Board of Trustees. At that time, if all your charges are in the acceptable range (within the 90th percentile), you will be invited to participate.

May we emphasize again the importance of this survey. If a Prevailing Fee Program is implemented, your replies would provide the basis for establishing your own individual Fee Schedule, as well as the range of prevailing fees for such a program as a whole.

Your cooperation in promptly returning each questionnaire as completed will be of invaluable assistance in implementing this program.

Sincerely yours,
Nicholas F. Alfano, M.D.
President

Dear Doctor — Participating or Non-Participating:

The importance of this letter cannot be overstated. It concerns an entirely new concept of payment by Blue Shield that may affect you personally to a greater extent than any other previous action of the Plan. One of its features is to establish a special class of participating physicians limited to this program regardless of whether or not they may be participating in the Plan's present programs.

Reasonable and customary, usual charges, prevailing fees, are terms denoting various concepts in the economics of prepaid medical care. They all do away with income tests for subscribers and fixed fee schedules. We at Blue Shield are aware of this trend and are attempting to do something about it.

The first step is to determine the cost of such a program and, hence, its feasibility. To do so, we are about to conduct a confidential survey of every practitioner in New Jersey, participating or non-participating, in order to determine his usual charge for each service he customarily performs. To project these findings into a contract with a rate structure that is meaningful, requires virtually 100% response to this survey —your cooperation is vital if we are to move forward.

You will receive one or more questionnaires in the very near future with a covering letter which will explain in greater detail the mechanisms of the Blue Shield Prevailing Fee Survey. Meanwhile, a brief explanation of the prevailing fee concept is in order. The essential elements follow:

1. For purposes of establishing levels of medical charges, prevailing fees will be determined for geographic areas in which economic characteristics are known to be homogeneous. Thus, prevailing fee payments for medical services would relate consistently to all other economic characteristics in the area in which they are to be made. New Jersey, being fairly homogeneous, may require up to three divisions insofar as economic levels are concerned.

2. The prevailing fee concept takes into account physician specialty and the usual fees of other doctors in the same area who perform the same service or procedure.

3. Each physician, through the survey questionnaire(s), reports his usual charges (the charges he makes to most of his patients) for each procedure he commonly performs.

4. The survey will provide two essential sets of facts:

 a. The individual fee schedule used by each physician in the state who replies to this survey.

 b. A range of charges for each procedure surveyed.

 From this data, the Plan will compile a range of fees that will fully cover at least 90% of the claims and pay in full at least 90% of the physicians.

5. A physician whose usual charges fall within the 90th percentile will be offered the opportunity to participate in the Prevailing Fee Program, and if he accepts, will be paid his usual charges, as indicated by his fee schedule on file with the Plan. Such special participation is confined to the Prevailing Fee Program.

6. After initiation of this program, if a physician makes an adjustment in his usual charge for one or more services, to all his patients, he may revise those charges as filed with the Plan, and that change will become effective 90 days after receipt of such written notification provided that the new charge remains within the 90th percentile.

7. Periodic review will be conducted to make certain that the Plan's range of charges for each procedure continues to reflect the true range for that procedure in the geographic area.

8. Physicians who initially report one or more usual charges that prove to be in excess of the 90th percentile, will be given the opportunity to adjust those charges to bring them within the 90th percentile.

9. Non-participating physicians — those who have one or more usual charges which do not fall within the 90th percentile, or who do not furnish sufficient data to the Plan to establish an acceptable profile, or who elect not to participate, will have their services paid for at a fixed rate within the prevailing fee range for those services, and that payment will be made to the subscriber.

To summarize, the Prevailing Fee Program basically is an improved "usual and customary" program unique with Blue Shield. It guarantees to pay in full the charges of the vast majority of physicians. Each physician who qualifies and accepts participation in this program, will be fully compensated for his services according to his usual and customary charges. The new and improved feature of the Prevailing Fee Program is that this guarantee is made in advance of the performance of the service and at a predictable cost to the purchaser.

In closing, the Plan wishes to emphasize that this survey is not merely a fact finding exercise. An important purchaser of health insurance, by labor-management negotiation, has agreed to purchase this type of program for an effective date of August 1, 1967. If a product can be produced that is satisfactory to the Plan's Board of Trustees, the physicians of New Jersey, and the purchaser, a milestone in health insurance in New Jersey will have been passed.

May we earnestly solicit your cooperation in this undertaking, and express in advance our thanks for it.

Sincerely yours,
Nicholas F. Alfano, M.D.
President

AMA Book On Cosmetics

To meet heavy public demand for authoritative information concerning skin and cosmetic problems, the American Medical Association has published a new paperback entitled, *The Look You Like.*

Packed with information on the use and abuse of cosmetic preparations, the subject matter contained in the 129-page publication was gleaned from *The Look You Like* question and answer column, which has been a regular feature of TODAY'S HEALTH since 1962. Answers to all questions appearing in this column are written with the help of outside consultants in industry and the medical profession who are considered authorities on the question at hand. Subject matter is reviewed by members of the Committee on Cutaneous Health and Cosmetics.

Retail sales of cosmetics will surpass the $4 billion mark this year. Considering the extensive number of people who use cosmetics and the wide range they have to select from, it is certain that occasional reactions to cosmetic programs will occur. The new book was prepared as a guide to help individuals avoid or overcome such problems.

The Look You Like may be obtained from the Order Department, AMA, 535 North Dearborn Street, Chicago, Illinois 60610. Single copies are $1.70. There is a special rate for medical students, interns, and residents.

Nominations for Emeritus Membership

(Reference Committee "H")

The following nominations for election to emeritus membership at the 1967 annual meeting have been received from the component societies. Conforming to the provisions of Article IV, Section 6, of the Constitution, all nominees are now and have been members in good standing of a component society for at least twenty years, and by reason of age or infirmity have retired from the active practice of medicine. All are emeritus members of their respective component societies.

Bergen County

Charles G. Prather, Jupiter, Fla. (formerly Westwood); Age 63

Camden County

Samuel Goldman, Camden; Age 68
A. M. K. Maldeis, Haddonfield; Age 75
Edwin R. Ristine, Mantua; Age 61

Cumberland County

H. Burton Walker, Englewood, Colo. formerly Vineland); Age 77

Essex County

Irving L. Applebaum, East Orange; Age 62
Joseph F. Barrett, Maplewood; Age 68
Royal M. Cohn, South Orange; Age 81
George C. Freeman, Millington (formerly Newark); Age 68
George H. Jackson, Port Perry, Ontario, Can. (formerly Union); Age 63
John F. Judge, Rockaway (formerly South Orange); Age 63
James V. Lyons, Rumson (formerly Orange); Age 69
Otto G. Matheke, Sr., East Orange; Age 85
Herbert A. Schulte, Denville (formerly Newark); Age 72
Thornton Stearns, Orange; Age 81
Richard F. Tomec, Brielle (formerly Montclair); Age 65

Hudson County

Ben B. Markowitz, Jersey City; Age 75

Middlesex County

Harry J. White, Metuchen; Age 69

Passaic County

Edward Ehrenfeld, Palm Beach, Fla. (formerly Passaic); Age 67
Louis G. Shapiro, Fort Lee (formerly Paterson); Age 75

Union County

Lawrence G. Beisler, Hillside; Age 73
Wilton J. Hallock, Summit; Age 68
Ernest I. Kyle, Plainfield; Age 73

Approved (page 417)

Supplemental Report

The following additional nominations for election to emeritus membership were received:

Atlantic County

Robert A. Bradley, M.D., Margate City; age 72
Martin H. Gold, M.D., Margate City; age 72

Approved (page 417)

RESOLUTIONS

#1

AMA House of Delegates' Sessions

From the Essex County Medical Society

(Reference Committee "A")

Whereas, the American Medical Association presently holds one Annual Convention and one Clinical Session a year at which important scientific medical advances and scientific papers are presented; and

Whereas, reporters present at these meetings file copy primarily on the socio-economic and political actions of the House of Delegates; and

Whereas, this House of Delegates' news in all of the nation's media tends to overshadow or relegate to the back pages the important scientific work done by physicians; and

Whereas, deserving media coverage of these scientific advances would enhance the public relations of the profession; now therefore be it

RESOLVED, that the American Medical Association be requested to hold its House of Delegates' sessions at a time and place that would be completely separate and distinct from their scientific sessions so that better coverage will be afforded the marvelous new discoveries, techniques, and innovations advanced at scientific meetings; and be it further

RESOLVED, that the Delegates from The Medical Society of New Jersey to the AMA be directed to do all in their power to implement such a change in AMA convention format.

Disapproved, because separation of sessions of the House of Delegates from scientific sessions would be a disservice to members and delegates, especially in relation to tax considerations **(page 401)**

"Strip Pack" Helps Prevent Childhood Poisoning

The greatest cause of accidental poisoning among children is adult aspirin. This is especially true when the child ingests the tablet. The conventional screw cap on a bottle is an invitation to a bright child, who can easily open it. Several types of safety packaging have been tried. One reported as especially successful is the "strip pack." The report is from Dr. Alan K. Done of the University of Utah, who announced his findings to the American Academy of Pediatrics at its meeting in April 1967. A study was developed by putting candy pellets in three types of packaging. One was the conventional screw cap; another was the new so-called safety closure; and the third was the "strip pack." The experiment was tried to find out how many pellets a child could consume in 30 minutes after getting his hands on the bottle or package. The answer was 50 for the screw cap, 25 for the safety closure, and 9 for the "strip pack."

#2

Changing Concept of Medical-Surgical Plan of New Jersey

From the Mercer County Medical Society

(Reference Committee "C")

Whereas, the Medical-Surgical Plan of New Jersey at its inception in 1942 was devised and promulgated for the purpose of providing total and adequate medical services for people in the lower income class whose single income was not to exceed $2,500 or whose family income was not to exceed $3,100; and

Whereas, during the past several years the income limit has been periodically raised without consultation with the participating physicians and now has been brought to the level of $5,000 single, or $7,500 family income; and

Whereas, the Medical-Surgical Plan of New Jersey has recently issued a contract (effective and retroactive to September 1, 1966) to various industries called the "Motors Program," which program will be accompanied by about a 15% increase in fees to physicians, but raised the level of income again (and this time with practically no limit to income) to $7,500 *employee only,* based on the *subscriber's annual base wage* or *salary earnings,* no other income, either his or of his dependents, if any, being counted; and

Whereas, the covered employee and/or the spouse or dependent may have a total income annually far in excess of $7,500 but may *not* be charged more by the participating physician than the proposed fee set up by the Medical-Surgical Plan of New Jersey; and

Whereas, the original concept of medical care of persons of low income seems no longer the basic factor with Blue Shield and, if this is the case, Blue Shield may be compared to a commercially motivated insurance company using the lower fees paid to participating physicians as a means to compete at lower rates with other commercially motivated insurance companies; and

Whereas, total coverage should no longer be the basic concept of Blue Shield fee coverage if its subscribers no longer are in the low income class; now therefore be it

RESOLVED, that the Medical-Surgical Plan of New Jersey, since it apparently no longer adheres to the basic concept of medical care for the persons of low income, adopt a method of reimbursement similar to other insurance companies, guaranteeing to the patient a certain definite payment for certain medical or surgical procedures permitting the physician to charge his standard fee, if he so desires, to the patient — a so-called indemnity plan; and be it further

RESOLVED, that if the Board of Trustees of the Medical-Surgical Plan of New Jersey really believes Blue Shield should continue as a total payment plan for persons of low income, it then revise immediately the "Motors Program" (#575M) and place it in its proper category with the same maximums as the regular type plan (#500); and be it further

RESOLVED, that all future major changes in the philosophy of coverage be openly and democratically exposed to the participating physicians for their approval; and be it further

RESOLVED, that a copy of this resolution be forwarded to the Board of Trustees of the Medical-Surgical Plan of New Jersey, the Board of Trustees of MSNJ, each county society, and be presented on the floor of the House of Delegates for appropriate action and recommendations.

Disapproved (page 406)

#3

Hospital Utilization Committees and The AID Program

From the Middlesex County Medical Society

(Reference Committee "C")

Whereas, hospital utilization committees are presently certifying the necessity for patient stay; and

Whereas, many utilization committees routinely use AID figures in calculating these needs in a convenient way; and

Whereas, AID certification is duplicating, in a less effective way, the work of utilization committees; now therefore be it

RESOLVED, that utilization committees be encouraged to use up-to-date AID figures in their work; and be it further

RESOLVED, that AID certification be stopped, to avoid duplicating utilization committee work.

Disapproved (page 406)

#4

New Jersey Commissioner Of Banking And Insurance

From the Middlesex County Medical Society

(Reference Committee "C")

Resolution #4 was withdrawn in the reference committee by the Middlesex County Medical Society (page 406)

#5

Group Automobile Insurance Coverage

From the Essex County Medical Society

(Reference Committee "D")

Whereas, individual automobile insurance coverage for people over age 65 is becoming increasingly hard to obtain; and

Whereas, physicians require auto insurance to practice medicine; and

Whereas, many of our members are still maintaining an active or limited practice over age 65; and

Whereas, a group plan could be so arranged to get coverage for all members who require it; and

Whereas, this is and will be an increasingly difficult statewide problem; now therefore be it

RESOLVED, that The Medical Society of New Jersey investigate the possibility of providing a group automobile coverage for its members; and be it further

RESOLVED, that the House of Delegates empower the Committee on Medical Defense and Insurance to investigate and act on this recommendation.

Adopted **(page 408)**

#6

Annual Awards For Outstanding News Reporting Of Medical Topics

From the Burlington County Medical Society

(Reference Committee "E")

Whereas, the various news media reach all levels of society and are a potent source of public opinion; and

Whereas, accurate reporting of medical topics is of great importance and benefit to both the medical and lay public; and

Whereas, it is the mutual obligation of The Medical Society of New Jersey and the various news media to recognize and encourage outstanding examples of reporting in the fields of medicine and health; and

Whereas, similar programs of recognition instituted by the Pennsylvania Medical Society and the American Medical Association have been of proven value in improving the quality and quantity of such reporting; therefore be it

RESOLVED, that The Medical Society of New Jersey establish a series of duplicate awards for outstanding examples of reporting of medical topics by the radio, television, and newspaper media; and be it further

RESOLVED, that each such award consist of a plaque plus an honorarium of $100 to each recipient; and be it further

RESOLVED, that these awards be made annually in recognition of reporting during the preceding calendar year; and be it further

RESOLVED, that judging and the receipt of all nominations for these awards be a function of the Public Relations Council of The Medical Society of New Jersey.

Not Adopted. The committee considered this resolution in detail. While it took no exception to the intent, language, or provisions of the resolution, it questioned whether or not—in light of AMA activities in this field—such a resolution is truly necessary for New Jersey. **(page 409)**

#7

Chiropractic As An Unscientific Cult

From the Bergen County Medical Society

(Reference Committee "E")

Whereas, the American Medical Association has officially stated that Chiropractic is an unscientific cult whose practitioners lack the necessary training and background to diagnose and treat human disease, and constitutes a hazard to rational health care in the United States because of the sub-standard and unscientific education of its practitioners and their rigid adherence to an irrational unscientific approach to disease causation; and

Whereas, the nation's highest courts have affirmed a state's constitutional right to refuse to license chiropractors; therefore be it

RESOLVED, that the Bergen County Medical Society fully endorses these policy statements of the American Medical Association 1966 House of Delegates; and be it further

RESOLVED, in the interest of the health of the public of New Jersey, that this resolution be referred to the Legislative Committee of the House of Delegates for the purpose of drawing up a new statute to modify the present Medical Practice Act of New Jersey so as better to accomplish the proper regulation of the practice of chiropractic in order to protect the health of the people of New Jersey; and be it further

RESOLVED, that this resolution be forwarded to The Medical Society of New Jersey for immediate action to promote legislation which will protect the people of New Jersey against the hazard of chiropractic.

Recommendation of the reference committee approved: That the House adopt the following substitute for Resolutions #7 and #8:

Whereas, Title 45, Chapter 9 of the Revised Statutes of New Jersey governing the practice of medicine and surgery is based for the most part upon statutes enacted at the turn of the century; and

Whereas, these statutes have become outmoded by technological developments, federal legislation, and reorganization of state government; and

Whereas, the existing statutes adversely affect the public welfare; now therefore be it

RESOLVED, that a committee be appointed by the President of MSNJ to review all statutes related to the practice of medicine and surgery in this State and to submit specific recommendations for their revision to the Board of Trustees as quickly as possible. (page 409)

#8

Medical Ancillary Personnel

From the Passaic County Medical Society

(Reference Committee "E")

Whereas, efficient medical care can best be served by the recognition of the traditional right of the physician to employ and/or train necessary ancillary help; now therefore be it

RESOLVED, that The Medical Society of New Jersey, both through its Board of Trustees and through its Delegates in the American Medical Association, initiate appropriate legislation recognizing the traditional right of physicians to employ and/or train such ancillary help as the proper practice of medicine and the best interests of patients shall require; and be it further

RESOLVED, that the Medical Practice Act of New Jersey be reviewed and appropriate steps be taken with respect thereto, to reflect the needs of modern medicine and its specialties.

Recommendation of the reference committee approved: That the House adopt the following substitute for Resolutions #7 and #8:

Whereas, Title 45, Chapter 9 of the Revised Statutes of New Jersey governing the practice of medicine and surgery is based for the most part upon statutes enacted at the turn of the century; and

Whereas, these statutes have become outmoded by technological developments, federal legislation, and reorganization of state government; and

Whereas, the existing statutes adversely affect the public welfare; now therefore be it

RESOLVED, that a committee be appointed by the President of MSNJ to review all statutes related to the practice of medicine and surgery in this State and to submit specific recommendations for their revision to the Board of Trustees as quickly as possible. (page 409)

#9

Generic Versus Proprietary Drugs

From the Essex County Medical Society

(Reference Committee "F")

Whereas, the generic or non-proprietary name of a drug refers to the active chemical ingredient of the drug and not to the finished product which is supplied to the patient; and

Whereas, in order that it may be dispensed, the trade-name manufacturer, by way of a specific formulation, processes the drug to its final form; and

Whereas, a manufacturer's preparation of a tablet form of a drug may contain many variables such as the crystalline size, the nature of the excipients, the coloring agents and flavors, the tableting pressures, coating films, and the orientation within the tablet; and

Whereas, the same generic chemical classification of a compound may emerge in any one of several forms, it becomes apparent that a generic-named drug supplied by one manufacturer may differ to a significant degree from the same generic-named drug suppplied by another; and

Whereas, if the physician is compelled to prescribe by generic name, he would have no control as to which drug is used by the pharmacist in filling the prescription; and

Whereas, the coating, the disintegration time, the solubility, the choice of vehicle or base, and other factors may be extremely important to the physician who selects a drug for a specific reaction in his patient; and

Whereas, the myth of "generic equivalence" was exploded long ago and there is as much difference between drugs with the same

generic name as there is between people with the same family name, and in the market place there are high quality products and low quality products and many grades in between; and

Whereas, medical, pharmaceutical, and other scientific annals, extending back more than twenty years, contain many convincing reports of investigations which persistently support the contention that generic identity does not necessarily assure equal therapeutic effectiveness; and

Whereas, the successive refills of the same prescription with products of different manufacturers could lead to variations in therapeutic response which may mislead the doctor and not be in the best interest of the patient; and

Whereas, patients may attempt to hold physicians responsible for reactions to drugs which were substituted for the originally prescribed drugs; and

Whereas, generic prescribing would not necessarily result in a saving to the patient, because it would allow the pharmacist to furnish the patient with the manufactured drug he has chosen, which might be more or less expensive than the brand-name the physician would have selected; therefore be it

RESOLVED, that the treating physician should have the choice (in all private paid, insurance paid, and government paid programs) of deciding whether or not to prescribe generically or by brand-name; and be it further

RESOLVED, that The Medical Society of New Jersey support the policy of freedom of choice of drugs by the physician in order to enable him to best serve his patients; and be it further

RESOLVED, that this resolution be submitted to the House of Delegates of the American Medical Association and that our New Jersey Delegates to the American Medical Association do all in their power to obtain its adoption at the national level.

Approved (page 412)

#10

Rentention Of Provision Under Part B Medicare Excluding Payment Of Interns And Residents

From Nathan J. Plavin, M.D., Delegate from Hudson County

(Reference Committee "F")

Whereas, Part B of the Medicare Law (Title XVIII – 89-97) was established to underwrite the costs of professional medical services rendered by licensed physicians freely chosen by covered beneficiaries; and

Whereas, Part B therefore relieves its eligible beneficiaries of the necessity of going to hospital clinics and being treated by physicians not of their own choosing; and

Whereas, Part B provides payment only to licensed physicians rendering personal services to eligible beneficiaries, and specifically excludes from such payment interns and residents whose services are compensable as hos-

pital services under Part A of the Medicare Program; and

Whereas, in June 1965, the House of Delegates of the American Medical Association adopted Resolution #6, approving and supporting the principle that medical-surgical insurance benefits should be paid only to private physicians for eligible professional services personally rendered to their private patients; and

Whereas, of late, many full-time directors and departmental chairmen of large community hospitals, teaching hospitals, and clinics have publicly urged that the Medicare Law be changed to authorize payment to interns and residents under Part B; now therefore be it

RESOLVED, that this convention reaffirm its support of the principle presently embodied in the Medicare Law, excluding payment to interns and residents under Part B; and be it further

Foregoing resolved amended to read:

RESOLVED, that MSNJ reaffirm its support of the principle presently embodied in the Medicare Law (Title 18) of payment for the costs of medical services to fully licensed physicians freely chosen by the beneficiaries, and of exclusion of payments under Part B to interns and residents; and be it further

RESOLVED, that a copy of this resolution be introduced in the House of Delegates of MSNJ at its forthcoming meeting in May 1967; and be it further

RESOLVED, that a second copy be delivered to the Board of Trustees of the American Academy of General Practice for its supporting action, with specific recommendation that every State Chapter be asked to introduce a like resolution at the next meeting of its state (constituent) medical society, so that each state society's delegates to the American Medical Association will be instructed to oppose any change in Part B of the Medicare Law which would provide payment for services of interns and residents.

Foregoing resolved amended to read:

RESOLVED, that this resolution be submitted to the House of Delegates of the AMA and that our AMA Delegates do all in their power to obtain its adoption at the national level.

Adopted as amended (page 412)

#11

Title XIX Assistance Program

From the Essex County Medical Society

(Reference Committee "F")

Whereas, the State of New Jersey will shortly be in the process of setting up a Title XIX Medical Assistance Program (Medicaid); and

Whereas, the Title XIX Medical Assistance Plan is probably the most important state-administered medical program that ever will receive legislative approval; and

Whereas, it has caused considerable concern among medical practitioners — as in New York and Kentucky; therefore be it

RESOLVED, that The Medical Society of New Jersey do all in its power to assure adequate physician representation on all state committees involved with the setting up of a Title XIX Plan for New Jersey; and be it further

RESOLVED, that The Medical Society of New Jersey attempt to have the following four parts included in the Title XIX Plan:

1) Assure the beneficiary of free choice of physician or hospital;

2) Provide payment of physicians' services on the basis of usual and customary fees;

3) Work for the designation of a qualified insurance carrier to handle claims and payment of charges for medical services; and

4) Permit direct billing to the beneficiary, the agency, or the carrier on the basis of usual and customary fees rather than assignment from the patient authorizing payment by the agency or carrier.

Foregoing resolved amended to read:

RESOLVED, that MSNJ attempt to have the following four parts included in the Title XIX Plan:

1. Assure the beneficiary of free choice of physician and hospital;

2. Provide payment of the physician's services on the basis of his usual and customary fees;

3. Work for the designation of a qualified insurance carrier to handle claims and payment of charges for medical services; and

4. Permit billing to the beneficiary, or to the agency or carrier, on the basis of usual and customary fees, without requiring assignment from the patient.

Adopted as amended (page 413)

#12

Utilization Review Committee Immunity

From the Essex County Medical Society

(Reference Committee "F")

Whereas, under Public Law 89-97 utilization review committees are not empowered to discharge patients from the hospital; and

Whereas, such discharge continues to be the decision of the physician responsible for the patient's care, with the committee determining only the continued fiscal responsibility of the federal government; and

Whereas, legal opinion raises serious question as to the Congress' authority to grant immunity from litigation which is essentially civil in nature and governed by state law; and

Whereas, a number of state legislatures have granted such protection to physicians; now therefore be it

RESOLVED, that The Medical Society of New Jersey be urged to seek the passage of State legislation which would provide a physician who serves on a utilization review committee immunity from litigation arising from the actions of the committee.

Foregoing RESOLVED amended to read:

RESOLVED, that MSNJ be urged to seek the passage of state legislation which would provide a physician who serves on any utilization review committee immunity from litigation arising from the actions of the committee.

Approved as amended (page 413)

#13

Community Mental Health Centers

From the Passaic County Medical Society

(Reference Committee "G")

Whereas, Community Mental Health Centers should be under medical, preferably psychiatric, leadership; and

Whereas, the medical profession should be urged to develop as much involvement as possible in the planning and implementation for Community Mental Health Services; now therefore be it

RESOLVED, that at least two rooms in each hospital should be so equipped that they could be converted to quiet rooms for the care of acutely disturbed patients; and be it further

RESOLVED, that a general hospital should be the nucleus of a Community Mental Health Center.

Recommendation of the reference committee approved as amended by the House: That the House adopt the following amended version for Resolution #13:

Whereas, it has been recognized that the medical profession, which has medical, legal, and moral responsibilities (and the psychiatric specialty within that profession) is the appropriate profession to be delegated the responsibility of treating mentally ill individuals; and

Foregoing paragraph amended by the House to read:

Whereas, it has been recognized that the medical profession has the medical, legal, and moral responsibilities for treating mentally ill individuals; and

Whereas, it has been recognized that "somatic" and "mental" symptoms may be facets of one and the same illness and that there is an inter-relationship between somatic and psychic processes; and

Whereas, it is, therefore, incumbent of the medical profession to be involved maximally in the planning and implementation of Community Mental Health Services; and

Whereas, it follows that Community Mental Health Centers should be under medical—preferably psychiatric—leadership; now therefore be it

RESOLVED, that each general hospital be encouraged to provide specific inpatient facilities for treatment of acutely mentally ill patients—whether the onset of the patients' overt "mental" illnesses occurs in the course of their hospital treatment for "somatic" illness or occurs while they are in the community; and be it further

RESOLVED, that a general hospital should be the nucleus of a Community Mental Health Center.

(page 415)

Electrocardiography For The GP

Columbus Hospital will begin its 6th annual course in simplified electrocardiography for the family physician on Wednesday, October 11, 1967. The program includes 30 two-hour sessions extending to May 15, 1968. This course aims at giving the physician the basic knowledge needed for this subject. It provides maximum participation by students with individual instruction and exercises, both in the technical and diagnostic aspects of electrocardiography. Particular emphasis is placed on everyday problems such as myocardial infarction, arrhythmias, etc. Treatment (including intensive coronary care) is also stressed. For further information call area code 201, 485-3400 (Ext. 82), or write to Dr. Joseph Santangelo, 539 Mt. Prospect Avenue, Newark, New Jersey.

#14

Change In Convention Format

From the Essex County Medical Society

(Reference Committee "H")

Whereas, the third (or final) session of the House of Delegates of The Medical Society of New Jersey is the most important voting session on matters of policy for the medical profession of the State of New Jersey; and

Whereas, all reference committee reports are adopted, rejected, or changed at this session; and

Whereas, this session is regularly scheduled for the Tuesday of the annual convention; and

Whereas, The Medical Society of New Jersey Delegate attendance records for many years confirm that the best delegate attendance is had on Sunday of the annual convention; and

Whereas, policy matters should be decided when the most delegates can convene; now therefore be it

RESOLVED, that the convention format of The Medical Society of New Jersey be changed so that the first session of the House of Delegates would start on either Wednesday or Thursday, and the third session would fall on Sunday when most delegates can take part in decisions of policy.

Disapproved. It was the opinion of the reference committee that the percentage of attendance at the third session would not change favorably with a change of the day of the week (and, indeed, might decrease); that the problems of leaving Atlantic City on a Sunday might well prove more formidable than those encountered on a weekday; that the scheduling of reference committees for Friday morning with elections on Friday afternoon might stimulate general exodus of delegates the same day; and that sufficient advance notice now exists so that each delegate can effectively plan for his attendance under the present format. **(page 417)**

#15

Section On Plastic And Reconstructive Surgery

(Reference Committee "H")

From the Board of Trustees

Whereas, it has been reported that there are approximately thirty diplomates — or Board-Eligible diplomates — of the American Board of Plastic Surgery practicing in New Jersey; and

Whereas, of the fifty states, New Jersey reportedly has the sixth highest total of practicing plastic surgeons; and

Whereas, the New Jersey practitioners of this specialty have formally requested favorable consideration by The Medical Society of New Jersey of the formation of a new Scientific Section on Plastic and Reconstructive Surgery; and

Whereas, the Annual Meeting Committee of The Medical Society of New Jersey has formally recommended that the Society establish a Scientific Section on Plastic and Reconstructive Surgery; now therefore be it

RESOLVED, that the House of Delegates of MSNJ approve the recommendation of the Annual Meeting Committee and authorize the formation of a Scientific Section on Plastic and Reconstructive Surgery.

Approved. The House rejected the recommendation of the reference committee that Resolution #15 be disapproved. **(page 417)**

#16

Elimination Of Office Of "Eleventh Trustee"

From the Morris County Medical Society

(Reference Committee on Constitution and Bylaws)

Whereas, the "11th trustee" does not represent any district on the Board of Trustees of The Medical Society of New Jersey; and

Whereas, the position of the "11th trustee" gives inappropriate consideration to the members of his district; and

Whereas, the "11th trustee" is not necessary for "tie-breaking" since there are seven officers included on the Board of Trustees; and

Whereas, the regulations for succession to the position of the "11th trustee" have been vague and confusing in the past; therefore be it

RESOLVED, that the Constitution and Bylaws of The Medical Society of New Jersey be amended so as to eliminate the office of "11th trustee."

No action. The intent of Resolution #16 was accomplished in the amendment proposed by the Board of Trustees. **(page 419)**

#17

Board Of Trustee Representation From Judicial Districts

From the Bergen County Medical Society

(Reference Committee on Constitution and Bylaws)

Whereas, it is deemed desirable that the Board of Trustees of MSNJ provide representation of the members of MSNJ in approximately equal proportion; and

Whereas, the current method of allocating Trustees from five Judicial Districts of the state results in very disproportionate representation (see column (b) Exhibit A); and

Whereas, the report of the Ad Hoc Study Committee on Revision of the Constitution and Bylaws, as delineated in the minutes of MSNJ Board of Trustees' meeting of December 18, 1966, recommends changes in Judicial District representation on the Board of Trustees which will affect the Trustee proportionate representation of members very slightly (see column (c) Exhibit A); and

Whereas, another method of electing Judicial District representation on MSNJ Board of Trustees by making direct proportionate representation would create equal representation on the Board according to members' population in each Judicial District (see column (d) Exhibit A); now therefore be it

RESOLVED, that:

(1) The House of Delegates of MSNJ at its 201st Annual Meeting direct the Committee on Revision of Constitution and Bylaws of that Society to prepare an amendment to the Constitution which would provide that each Judicial District shall be represented on the Board of Trustees of MSNJ on the basis of one Trustee for each five hundred Active Members or major fraction thereof; and

(2) The number of Active Members in each Judicial District be reviewed every five years for the purpose of maintaining the ratio of one Trustee for every five hundred Active Members or fraction thereof; and

(3) The office of the eleventh Trustee be eliminated; and be it further

RESOLVED, that this resolution be forwarded forthwith to the Board of Trustees of MSNJ in order that it may appear on the agenda of the 201st Annual Meeting of that Society, and to the component county societies of MSNJ for their interest and information.

Disapproved, in view of approval of the amendment proposed by the Board of Trustees. (page 419)

EXHIBIT A

District	(a) Active Members	(b) Present Trustee Apportionment	(c) Apportionment Recommended By Ad Hoc Com.	(d) New Recommended Apportionment
First	2495	2 (1247)	3...(832)	5...(499)
Second	1953	2....(976)	3...(851)	4...(488)
Third	986	2....(493)	2...(493)	2...(493)
Fourth	1019	2....(509)	2...(509)	2...(509)
Fifth	418	2....(209)	2...(209)	1...(418)
Eleventh Trustee		1		
Total		11	12	14

N.B. Figures in parenthesis indicate number of Active Members of MSNJ represented by each Trustee under plan (b), (c), and (d) above.

#18

Insurance Coverage For State-Subsidized Patients

From the Morris County Medical Society

(Reference Committee "F")

Whereas, the State of New Jersey has provided for hospital payments in the form of insurance plans for patients receiving financial aid from public funds; and

Whereas, physicians have treated these patients without fee in the past; and

Whereas, new legislation, both federal and state, provides for financial aid to these patients for their medical care; now therefore be it

RESOLVED, that The Medical Society of New Jersey actively urge the various agencies involved in the medical care of patients who need financial aid from public funds to procure medical insurance plans for said patients, as well as the hospital insurance plans now provided.

Approved (page 413)

#19

Blood Bank Credits Under Blue Cross

From the Essex County Medical Society

(Reference Committee "C")

Whereas, there is an increased need in New Jersey for additional supplies of blood and blood components; and

Whereas, there is a need for new incentives for voluntary blood donations; and

Whereas, the cost for blood is at all times variable and frequently excessively costly; and

Whereas, the Essex County Medical Society is interested in maintaining and expanding existing blood programs through the participation of all qualified blood collecting installations in the New Jersey area; and

Whereas, provisions are made in Blue Cross plans in many states for the payment of processing charges and/or blood; and

Whereas, such plans reduce to pennies this hospital charge for blood or blood processing as well as assist and encourage the voluntary donor programs; therefore be it

RESOLVED, that the Essex County Medical Society hereby urge the Hospital Service Plan of New Jersey and the New Jersey Hospital Association to consider a plan wherein all its subscribers may have an option under their present Blue Cross plan, as follows:

If the subscriber chooses to deposit one unit of blood annually, he and his Blue Cross dependents shall be entitled to receive all of the blood or blood derivatives he or his dependents should need, with no charge for the blood or processing cost of said blood; and that, further, a plan will be devised for members of Blue Cross groups to make deposits of blood based on a yet to be determined percentage of the membership of the group; participants of such a plan and all family dependents covered under the contract will be eligible for the above stated benefits; and be it further

RESOLVED, that, in order effectively to administer a program of such magnitude, it is suggested that the facilities of one or more of the existing blood banks in the State of New Jersey be used to collect, process, coordinate, and administer the program; and be it further

RESOLVED, that this resolution be forwarded to The Medical Society of New Jersey, so that it may take similar action at its annual meeting.

Approved (page 406)

1966 TRANSACTIONS

At its first session on Saturday afternoon, May 13, 1967, the House of Delegates approved the Transactions of the 1966 House of Delegates as published in the August 1966 issue of THE JOURNAL and distributed to the membership.

#20

Restriction Of Membership On Councils/Committees

From the Mercer County Medical Society

(Reference Committee "A")

Whereas, The Medical Society of New Jersey has a great many gifted and valuable members whose services are available but rarely utilized; and

Whereas, these members frequently do not have the opportunity necessary to develop their skills or contacts in service for the Society, since they lack the experience usually obtained only after serving as appointees on committees and other appointments available to members of the Society since these appointments are frequently pre-empted by a few members who often hold one or more elected positions and serve Medical Society appointments on committees, associations, civic groups, government positions, etc.; and

Whereas, the use of any one individual to serve in several elected and/or several Society controlled appointments is first, an unnecessary load on an individual and, second, can be a disservice to the Society since he may not be able to perform the many duties as thoroughly and efficiently as he should; and therefore be it

RESOLVED, that the House of Delegates go on record as opposing the election of any one member to more than one position available to The Medical Society of New Jersey and, if elected, restrict the same member to only one committee or other appointment available through the action of the Society or its officers.

Foregoing RESOLVED amended to read:

RESOLVED, that the House of Delegates go on record as opposing the granting of multiple elective and/or appointive positions to any one member, and urges that hereafter this principle be observed.

Approved as amended (page 401)

#21

Retirement Plan For Physicians

From the Mercer County Medical Society

(Reference Committee "D")

Whereas, many physicians of New Jersey have subscribed to and are participating in retirement plans, especially those with the provisions of the so-called Keogh Bill; and

Whereas, many more physicians, due to lack of encouragement, carelessness, inadequate knowledge of its benefits, or pressures of practice, have not availed themselves of the many practical advantages found in joining a plan; and

Whereas, it is praiseworthy of the officers of the Medical Society to promote the benefits of an approved Retirement Plan and be the leaders in New Jersey of this conspicuously worthwhile endeavor; and

Whereas, the Board of Trustees about one and a half years ago did suggest in a letter addressed to the membership its favorable feelings toward the AMA plan, the Mercer County Society Retirement Plan, and the Retirement Plan of the New Jersey Academy of General Practice; now therefore be it

RESOLVED, that the Board of Trustees of The Medical Society of New Jersey be instructed by the House of Delegates to direct the retirement committee of the society to investigate these three plans, and others of equal merit, and after investigation adopt one as the one most favored by the society and announce this in its *Journal;* and be it further

RESOLVED, that this action be completed before the first of October in order that sufficient time will be available to organize and complete a campaign of enrollment before the end of the Year 1967; and be it further

RESOLVED, that this be presented to the House of Delegates of The Medical Society of New Jersey at its May 1967 meeting for appropriate action.

Not adopted. The reference committee was of the opinion that this resolution calls for action already being dealt with by the Committee on Retirement Plan for Physicians, as reflected in its annual report (page 408)

#22

Prohibition Of Advertisements And Solicitations By Practitioners Of The Healing Arts

From the Monmouth County Medical Society

(Reference Committee "E")

Whereas, by using advertising media openly to solicit patients, certain practitioners of the healing arts in New Jersey conduct themselves and their practices in such fashion as to violate accepted standards of ethical conduct and professional deportment, and to impair the status of the healing arts in the eyes of patients, colleagues, members of allied professions, and the general public alike; and

Whereas, such advertising and solicitation are frequently misleading and hostile to the public welfare; now therefore be it

RESOLVED, that The Medical Society of New Jersey take such steps as are necessary to induce the New Jersey Legislature to enact a bill to outlaw the use of advertising media to solicit patients; and be it further

RESOLVED, that The Medical Society of New Jersey assist in the preparation of said bill and pattern it along the lines laid down in similar measures introduced in the legislatures of other states; and be it further

RESOLVED, that The Medical Society of New Jersey solicit the cooperation of other groups of practitioners of the healing arts to effect the early enactment of a satisfactory measure.

Recommendation of the reference committee approved: That the House adopt the following substitute for Resolution #22:

Whereas, use of any media to advertise or to solicit patients by—or on behalf of—any healing art of its practitioners violates accepted standards of ethical conduct and professional deportment; and

Whereas, such advertising impairs the stature of the healing arts in the eyes of patients, colleagues, members of allied professions, and the general public alike; and

Whereas, such advertising is frequently misleading, to the detriment of public health; now therefore be it

RESOLVED, that MSNJ draft appropriate legislation prohibiting such advertising; and in cooperation with other groups of practitioners, arrange for the introduction of such legislation. (page 409)

#23

Medical-Dental School For South Jersey

From the Camden County Medical Society

(Reference Committee "D")

Whereas, there is an increasing demand for physicians and dentists in the State of New Jersey; and

Whereas, the state government has been lagging in founding medical and dental schools necessary to meet this demand; and

Whereas, state schools in other states are accepting fewer and fewer candidates from New Jersey; and

Whereas, unfilled internships in New Jersey hospitals as well as unfilled positions in our state and county institutions bring out the dire need for more graduates; and

Whereas, teaching hospitals and ample teaching cases are available in the southern end of the State; now be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey recognize the need for a third medical and dental school and that it be located in Southern New Jersey; and be it further

RESOLVED, that this House of Delegates instruct the Board of Trustees to use its good office to urge the Governor and the Legislature to establish a third School of Medicine and Dentistry and locate it in Southern New Jersey; and be it further

RESOLVED, that a copy of this resolution be sent the Governor and members of the Senate and Assembly of the State of New Jersey.

Adopted. The reference committee noted that the House had previously recorded itself as favoring the establishment of a third medical school. It seemed that the Camden County area has the facilities necessary for the establishment of such a school. (page 408)

Bill To Provide Federal Payment For Drugs

There is now before Congress the Dingell-Montoya Bill, which would include in Medicare the cost of the medications. It would pay, in addition to the hospital and physician's bills, for prescription drugs after the first $25. There is no limit set on the amount of drugs that would be paid for by Medicare, nor do the bills carry any provision for financing the cost of this addition to the program for which no estimates are made.

It is provided that once a year the government would publish a list of approved drugs and biologicals giving the generic name, and also the trade names under which these drugs are sold. Presumably any drug that did not carry government endorsement would not be included. The government would then set up a schedule of prices based on the pharmacist's cost of acquisition, plus "a reasonable fee for professional services."

#24

Blood Insurance Program

From the Passaic County Medical Society

(Reference Committee "C")

Whereas, as many labor organizations have secured health insurance coverage as a fringe benefit; and

Whereas, often such labor organizations will also bargain for and obtain financial indemnity to cover "blood" as well; and

Whereas, this financial "blood" coverage reduces the incentive of such groups to cover their blood needs by *blood donation;* therefore be it

RESOLVED, that The Medical Society of New Jersey urge all such groups to insure their blood needs by a blood insurance program, rather than through a financial insurance benefit; and be it further

RESOLVED, that the delegates of The Medical Society of New Jersey submit this resolution for similar action by the House of Delegates of the American Medical Association.

Approved **(page 406)**

#25

Seat Belts In Public Conveyances

From Middlesex County Medical Society

(Reference Committee "E")

Whereas, vehicular seat belts have been shown to reduce the incidence of accidental death and disability when properly installed and utilized; and

Whereas, the medical profession should initiate measures designed to promote the public safety; therefore be it

RESOLVED, that The Medical Society of New Jersey urge the Legislature of the State of New Jersey to pass legislation providing for mandatory installation of seat belts in public conveyances; notably buses, taxicabs, and limousines, as soon as possible.

Recommendation of the reference committee approved: That the House adopt the following substitute for Resolution #25:

Whereas, it has been established that vehicular seat belts reduce the incidence of accidental death and disability when properly installed and utilized; and

Whereas, the medical profession should support measures designed to promote the public safety; now therefore be it

RESOLVED, that MSNJ urge the legislature of the State of New Jersey to pass legislation providing for mandatory installation of seat belts in public conveyances. **(page 410)**

#26

New Legislation Relative To Diagnostic And Therapeutic Approaches On Minors With Suspected Or Proved Venereal Disease

From John Winslow, M.D., Delegate from Essex County

(Reference Committee "E")

Whereas, there is a venereal disease epidemic of major proportion among minors; and

Whereas, if the physician awaits parental consent before he starts therapy, a majority of minors would never return for medical treatment and continue to spread venereal disease; and

Whereas, the epidemic cannot be effectively controlled unless all infected minors can be reached for therapy; therefore be it

RESOLVED, that The Medical Society of New Jersey seek passage of legislation in the State Legislature which would make it unnecessary for a physician to obtain parental consent in the diagnostic and therapeutic procedures on minors with possible or proven venereal disease.

Recommendation of the reference committee approved: That the House adopt the following substitute for Resolution #26:

Whereas, in New Jersey venereal disease among minors is of epidemic proportions; and

Whereas, this daily growing epidemic constitutes a present menace to the public health and to the economy of the State; and

Whereas, a physician may not treat a minor without parental consent; and

Whereas, experience has proved that minors ill, or suspected of being ill, or infected with venereal disease are unwilling to seek or secure parental consent prior to requesting physicians' services for the treatment of this disease; and

Whereas, the initial treatment by a physician may render venereal disease non-communicable; and

Whereas, control of venereal disease can be effected quickly by rendering it non-communicable; now therefore be it

RESOLVED, that MSNJ memorialize the legislature of the State of New Jersey to pass, and the Governor to approve, legislation empowering physicians to treat minors ill, or suspected of being ill, with venereal disease without first securing parental consent.

Adopted **(page 410)**

#27

Repeal Of The Gross Recipts Tax On Unincorporated Business

From Howard H. Lehr, M.D. and Henry J. Mineur, M.D.,
Delegates from Union County

(Reference Committee "E")

Whereas, the gross receipts tax on unincorporated businesses is discriminatory taxation; and

Whereas, all gross receipts taxes are, by their very nature, unjust and do not reflect ability to pay; and

Whereas, history would indicate that a start of ¼ of 1 per cent is only a start; therefore be it

RESOLVED, that this House of Delegates direct the Board of Trustees of The Medical Society of New Jersey to make every effort to effect repeal of this legislation.

Recommendation of the reference committee approved: That the House adopt the following amended resolution for Resolution #27:

Whereas, Chapter 137, P. L. 1966 impases a discriminatory gross receipts tax an unincarparated businesses; and

Whereas, all gross receipts taxes are, by their nature, unjust and do not reflect ability to pay; and

Whereas, experience indicates that a tax af a quarter of 1% is anly a start; naw therefare be it

RESOLVED, that the New Jersey Legislature be urged to repeal Chapter 137, P. L. 1966.

Adapted **(page 411)**

MEMORIAL RESOLUTIONS

The fallawing memorial resolutions were received by the House with sarrawful cancurrence, without reference to a committee:

Edith Louise Madden 1911-1966

Whereas, God in His wisdom has seen fit to summon Edith Louise Maddon to her eternal reward; and

Whereas, in almost thirty-three years of continuous, diligent, and devoted service — culminating in her work as Administrative Secretary and Convention Manager — Mrs. Madden contributed to the growth and attainments of The Medical Society of New Jersey; and

Whereas, in consequence she has won an enduring place in the history of the Society and in the hearts of its members; now therefore be it

RESOLVED, that The Medical Society of New Jersey records its profound grief at her passing; and be it further

RESOLVED, that a copy of this resolution be placed in the archives of the Society, and that a further copy thereof be delivered to the husband and family of Mrs. Madden as an expression of heartfelt sympathy in their bereavement.

F. Clyde Bowers, M.D. 1908-1967

Whereas, the late-lamented F. Clyde Bowers, M.D., our 167th President, served as a distinguished and faithful officer and member of The Medical Society of New Jersey for more than thirty years; and

Whereas, as a diligent and gifted member of the State Board of Medical Examiners, he rendered sustained and valuable service to the medical profession and the people of New Jersey; and

Whereas, in his practice and throughout his life he consistently exemplified the exalted qualities of mind and heart which typify the highest standards of professional and personal conduct; now therefore be it

RESOLVED, that the Board of Trustees of The Medical Society of New Jersey records profound grief at his passing; and be it further

RESOLVED, that a copy of this resolution be spread upon the minutes of this meeting, and another copy, suitably prepared, be presented to his bereaved family.

Vincent Paul Butler, M.D. 1893-1967

Whereas, Almighty God has seen fit to summon from our midst His good servant and our beloved colleague, Vincent Paul Butler, M.D.; and

Whereas, with singular distinction through his entire career he served well The Medical Society of New Jersey and reflected honor upon it by his services both as member of the Judicial Council and as President; and

Whereas, as a member and as Secretary of the New Jersey State Board of Medical Examiners he contributed greatly to the honor of the medical profession and the welfare of the people of New Jersey; now therefore be it

RESOLVED, that the Board of Trustees of The Medical Society of New Jersey records its grief at his passing; and be it further

RESOLVED, that a copy of this resolution be spread upon the minutes of this meeting, and that another copy, suitably prepared, be presented to his bereaved family.

Daniel Francis Featherston, M.D. 1896-1966

Whereas, Almighty God has seen fit to summon from our midst our beloved colleague, Daniel Francis Featherston, M.D.; and

Whereas, through his long career Doctor Featherston distinguished himself as a worthy member of the profession of medicine and a servant and benefactor of mankind; and

Whereas, with singular and selfless devotion, he consistently served well the Monmouth County Component Medical Society and The Medical Society of New Jersey, whose Treasurer he was at the time of his death; now therefore be it

RESOLVED, that the Board of Trustees of The Medical Society of New Jersey records its profound grief at his passing; and be it further

RESOLVED, that a copy of this resolution be spread upon the minutes of the Board, and that a further copy, suitably prepared, be presented to Doctor Featherston's bereaved family in token of heartfelt sympathy.

L. Samuel Sica, M.D. 1885-1967

Whereas, after a long life of distinguished and endearing service, L. Samuel Sica has been called to his eternal reward; and

Whereas, in the course of his professional life he won eminence as a surgeon and loving respect as a man; and

Whereas, he rendered outstanding services to organized medicine — at county, state, and national levels — through his loyalty and efficiency to the duties which he successively assumed; and

Whereas, to all who knew him of the profession and of the laity, he was an inspiring example of all the best that is implicit in the terms "gentleman" and "friend"; now therefore be it

RESOLVED, that the Board of Trustees of The Medical Society of New Jersey — recalling him affectionately as Board Member and Chairman — records profound grief at his passing; and be it further

RESOLVED, that a copy of this resolution be spread upon the minutes of the Board, and that a further copy, suitably prepared, be presented to Dr. Sica's bereaved family in token of heartfelt sympathy.

REFERENCE COMMITTEES

Reference Committee "A"

John J. Crosby, Jr., M.D., Chairman

Reference Committee "A" met on Sunday, May 14, 1967, with all members present: Doctors Donald T. Akey, Charles Cunningham, Frederick W. Durham, Adolph R. Wichman, and the chairman. Approximately 20 delegates and members were present to discuss the various items under consideration.

1. **President** (page 289)

The committee *recommends* that the President's report be accepted with heartfelt thanks for all his labor on our behalf.

Adopted

2. **Board of Trustees** (page 297)

The committee *recommends* approval of the introductory portion of the report.

Adopted

a. **Academy of Medicine of New Jersey** (page 297)

The committee *recommends* approval of this report.

Adopted

b. **AMA Membership Dues Increase** (page 298)

c. **Discrimination in Admission of Physicians to Organized Medicine** (page 298)

d. **Osteopaths in the Armed Forces** (page 299)

e. **Schedule of AMA House of Delegates** (page 300)

The committee *recommends* that the foregoing four informational sections reflecting the arduous and efficient efforts of our AMA Delegates be approved with appreciation.

Adopted

f. **House of Delegates' Agenda** (page 298)

The committee *recommends* that this section be approved.

Adopted

g. **Joint Conference with Presidents of Component Societies** (page 299)

The committe feels that this is an extremely valuable tool in the workings of MSNJ and *recommends* approval of this section of the report.

Adopted

h. **Professional Liability Panel** (page 300)

The committee studied with satisfaction the report on the Professional Liability Panel and *recommends* that it be approved.

Adopted

i. **Rehabilitation Commission Examination** (page 300)

The committee *recommends* that this section of the report be approved.

Adopted

3. **Secretary** (page 291)

The committee *recommends* that the Secretary's report be approved and notes with

regret Doctor Greifinger's enforced absence at this time.

Adopted

4. **Judicial Council** (page 309)

The committee *recommends* that the report be approved.

Adopted

5. **Executive Director** (page 311)

The committee *recommends* that the report of the Executive Director be approved and thanks him for his continuous and dedicated service.

Adopted

6. **Credentials** (page 316)

The committee *recommends* approval of the report of the Credentials Committee.

Adopted

7. **Resolutions:**

a. **AMA House of Delegates' Sessions** (Essex County) — Resolution #1 (page 379)

The committee *recommends* that this resolution be disapproved because separation of sessions of the House of Delegates from scientific sessions would be a disservice to members and delegates, especially in relation to tax considerations.

Adopted

b. **Restriction of Membership of Councils/ Committees** (Mercer County) — Resolution #20 (page 393)

The committee recognizes the value of this resolution, but for clarification and less restrictive connotations, it offers the following substitute "resolved," with the approval of the Mercer County spokesman:

RESOLVED, that the House of Delegates go on record as opposing the granting of multiple elective and/or appointive positions to any one member, and urges that hereafter this principle be observed.

Adopted

I thank all the members of the Reference Committe for their fine cooperation.

Report as a whole adopted

Patronize Our Advertisers

The companies and places which advertise in this JOURNAL merit your support. The fact that their advertisements are here is assurance of their reputability. By placing these notices in these pages, they assist your JOURNAL and your Society.

Reference Committee "B"

Leopold E. Thron, M.D., Chairman

Reference Committee "B" met on Sunday, May 14, 1967, with all members present: Doctors Henry O. von Deilen, Harvey P. Einhorn, Raymond A. Taylor, C. Spencer Davison, and the chairman. Approximately 15 delegates and members were present to discuss the various items under consideration.

1. **Board of Trustees — Items**

a. **The Healing Art** (page 301)

The committee reaffirms the commendation of the Board of Trustees and thanks the co-authors, Fred B. Rogers, M.D. and Mrs. A. Reasoner Sayre, for their outstanding work.

Adopted

b. **Project Hope** (page 301)

This item was discussed and recommendations will be made under the item of Finance and Budget.

Adopted

2. **Treasurer** (page 292)

The committee reviewed the detailed report of the Treasurer, and several items were discussed with Dr. Lloyd. All items were explained to the satisfaction of everybody present. The reference committee commends the Treasurer on the thoroughness and details of his report, and *recommends* that the report of the Treasurer be approved. In addition, the reference committee *recommends* that the Treasurer investigate the feasibility and wisdom of obtaining greater return on investments.

Adopted

3. **Finance and Budget** (page 317)

The report of the Committee on Finance and Budget was reviewed and found to be concise, detailed, and very illuminating. The increase of the budget of approximately $8,000 was explained by the increased allocation to the Medical Student Loan Fund.

Adopted

a. **The Journal** (page 317)

The reference committee wishes to commend the operation of *The Journal* and notes that the deficit has again decreased. The committee *recommends* that this section be approved as presented.

Adopted

b. **Project Hope** (page 317)

The reference committee concurs in the recommendation of the Finance and Budget Committee to continue the pilot project for 1967-68 providing for six fellowships, each carrying a stipend of $1,000; total $6,000. The committee *recommends* that this section be approved.

Adopted

c. **Special Per Capita Assessment** (page 317)

Following prolonged discussion, which included the availability and importance of the services of the Academy of Medicine and its library to The Medical Society of New Jersey, the reference committee *recommends* approval of the special per capita assessment of $5.00 in addition to, and not as part of, the budgetary assessment. The reference committee further *recommends* that the Academy of Medicine make known to the general membership details of all postgraduate educational facilities which are offered.

Adopted

d. **The 1968 Assessment** (page 318)

The reference committee *recommends* that the 1968 assessment be adopted at $40.00 per capita with no provision for a contribution to AMA-ERF.

Adopted

e. **1967-68 Budget** (page 319-320)

The reference committee *recommends* that the 1967-68 budget be adopted in the total sum of $288,217. The committee wishes to express its appreciation to the Finance and Budget Committee for the advance detailed breakdown sent to each member, and suggests this policy be continued in the future. The committee *recommends* that the report of the Finance and Budget Committee be approved as presented.

Adopted

4. **Medical Student Loan Fund** (page 326)

The reference committee hereby commends Dr. Mulligan and his committee for their efforts in behalf of furthering medical education by making the economic stress and strain more endurable for medical students. The committee again suggests that measures be continued by the Medical Student Loan Fund to see that recipients of loans will intern in New Jersey hospitals. The committee *recommends* the approval of the report of the Medical Student Loan Fund.

Adopted

5. **Publication** (page 330)

The Publication Committee is hereby commended for its work in publishing a *Journal* second to none. Specifically, the reference committee commends Dr. Sharbaugh, Dr. Davidson, and Mrs. Treptow for their successful efforts to reduce operating expenses.

The reference committee further commends Joseph W. Cookson, the new Advertising Manager, for his activities in this regard.

The committee *recommends* the approval of the report of the Publication Committee.

Adopted

Report as a whole adopted

Reference Committee "C"

Elbert H. Pogue, M.D., Chairman

Reference Committee "C" met on Sunday, May 14, 1967, with all members present: Doctors Dorsett L. Spurgeon, C. Scott McKinley, Edward A. Schauer, Robert H. Areson, and the chairman. Approximately 50 delegates and members were present to discuss the various items under consideration. Dr. Edward Bourns acted as Sergeant-at-Arms. In addition, Mr. Harry Jones, Vice-President of Blue Cross, and Mr. Vanderbilt, Legal Counsel for Blue Shield, were present.

1. **Board of Trustees — Items**

a. **AID Program** (page 301)

The report of the Board of Trustees on the AID Program was discussed. Resolution #3 from the Middlesex County Medical Society was discussed at the same time.

The committee *recommends* approval of the Trustees' recommendation for continuance of the AID Program.

Adopted

The committee *recommends* that Resolution #3 not be approved at this time, but feels that the points made in Resolution #3 should be kept in mind and that eventually well organized and functioning hospital utilization committees will make the AID Program unnecessary.

Adopted

The committee *recommends* approval of this portion of the report.

Adopted

b. **Blue Cross Homemaker Health Aide Project** (page 302)

This matter had previously been reviewed by the Board of Trustees of The Medical Society of New Jersey. The Board of Trustees had concluded that it could not endorse the program because it offered a service that:

1. Seemed to embody duplication of services already being supplied by the Visiting Nurses' Association and the Homemakers' Service;

2. Placed the physician in legal and liability jeopardy by asking him to use personnel not legally permitted to him under the Medical Practice Act;

3. Imposed upon the attending physician the responsibility for the control of utilization;

4. Foreshadowed an inevitable increase in subscription expenditures for Blue Cross Plan if it is added to its available coverages;

5. Set levels of compensation for Health Care Aides at an hourly figure higher than that received by hospital personnel of similar competences, and in consequence might deplete the ranks of present hospital personnel.

The Board had recommended that component societies take positions locally on the basis of the action taken by the MSNJ Board. There was much discussion, including explanatory remarks by Mr. Harry Jones, Vice-President of Blue Cross, who spoke in favor of the project. However, the members of Reference Committee "C" were of the unanimous opinion that such a project is fraught with danger and is undesirable for the same reasons given by the Board of Trustees, and *recommends* that it be not approved.

Adopted

c. **MSA Board of Governors — Nominations** (page 302)

The committee *recommends* approval of the nominations as submitted.

Adopted

d. **MSP Board of Trustees — Nominations** (page 302)

The committee *recommends* approval of the nominations as submitted by the Medical-Surgical Plan Board of Trustees and approved by the Board of Trustees of The Medical Society of New Jersey.

Adopted

However, it was felt that it should be made clear to the House of Delegates just what procedure is used in selecting Trustees for the Medical-Surgical Plan.

The Nominating Committee of the Medical-Surgical Plan submits a list of nominees to the Board of Trustees of the Medical-Surgical Plan. The Board of Trustees of the Medical-Surgical Plan approves the list and refers it to the Board of Trustees of The Medical Society of New Jersey. This list is approved by the Board of Trustees of The Medical Society of New Jersey and then is referred to the House of Delegates for action.

The question was raised as to what would happen if the Trustees of The Medical Society of New Jersey or the House of Delegates refused to approve the list of names submitted. If the action of the Board of Trustees of The Medical Society of New Jersey and the House of Delegates is to have more than a "rubber stamp" significance, then certainly The Medical Society of New Jersey can refuse to approve the names submitted in whole or in part. Dr. Alfano explained that if the names submitted were not approved by the Trustees and House of Delegates of The Medical Society of New Jersey, then other names would have to be submitted from Medical-Surgical Plan.

As a result of the prolonged discussion, the following suggestions are presented for consideration by the Medical-Surgical Plan:

1. That the number of terms to be served by the Trustees of Medical-Surgical Plan be limited.

2. That efforts be made to secure "new blood" in the organization, and that major changes should not be made primarily because of the death or resignation of a member of Medical-Surgical Plan Board of Trustees.

3. That the Medical-Surgical Plan Board consider the desirability of receiving nominations of physicians for membership on its Board from the Nominating Committe of The Medical Society of New Jersey.

The foregoing suggestions are not intended by your reference committee to imply, in any way, that the Trustees of the Medical-Surgical Plan have not been commendably diligent in the performance of their duties.

It was pointed out by Dr. Alfano that the number of lay members on the Board of Trustees of Medical-Surgical Plan has been increased, and that this has proved a healthy development, helpful from the standpoint of both internal operations and public relations.

The committee *recommends* approval of this portion of the report.

Adopted

e. **Public Hearing on MSP Rate Increase** (page 302)

Attention was called to Dr. Jehl's statement published in the *Membership News Letter.* A rate increase of 24.7% was requested by Blue Shield and a rate increase of 12% was granted by Commissioner Howell.

The question of hospital-based specialists was discussed and Dr. Alfano pointed out that if radiologists and pathologists are to be shifted from Blue Cross to Blue Shield, then rate increases will be necessary for Blue Shield subscribers. He also pointed out that the Medical-Surgical Plan of New Jersey is the only such plan in the nation not allowed experience rating to determine the rates charged to subscribers. Thus for each rate increase, Medical-Surgical Plan has to go to the Commissioner of Banking and Insurance for approval. This situation remains despite the recommendation of the Dumont Commission for such experience rating guidelines.

The committee *recommends* approval of this portion of the report.

Adopted

2. **Medical-Surgical Plan of New Jersey**

a. **MSP Coverage for National Accounts** (pages 308, 375)

This is a prevailing fee program for those experience-rated national accounts which desire such a program.

The committee feels that this should be favorably considered by the House of Delegates and that this entire situation should be reviewed by the House at its next annual meeting in 1968 for the purpose of critical evaluation in the light of the year's experience.

The committee *recommends* approval of this portion of the report.

Adopted

b. **"Blue Cross and Blue Shield Over 65 Program"** (page 375)

This program is for the issuance of a rider similar to, but more inclusive than Rider J for those with Blue Cross and Blue Shield coverage who are over 65.

The committee *recommends* approval of this program as submitted by the Medical-Surgical Plan.

Adopted

c. **Report on the Medical-Surgical Plan of New Jersey** (page 366)

Dr. Alfano's very complete report on the Medical-Surgical Plan of New Jersey was reviewed.

The committee *recommends* approval of this report.

Adopted

3. **Resolutions**

a. **Changing Concepts of Medical-Surgical Plan of New Jersey** (Mercer County)—Resolution #2 (page 380)

The committee *recommends* that this resolution be disapproved.

Adopted

b. **Hospital Utilization Committees and the AID Program** (Middlesex County) — Resolution #3 (page 381)

This has already been referred to in the portion of this report covering the AID Program.

The committee *recommends* that this resolution be disapproved.

Adopted

c. **New Jersey Commissioner of Banking and Insurance** (Middlesex County) — Resolution #4 (page 381)

In the reference committee meeting, this resolution was withdrawn by Middlesex County.

d. **Blood Bank Credits under Blue Cross** (Essex County) — Resolution #19 (page 392)

The committee *recommends* that this resolution be approved.

Adopted

e. **Blood Insurance Program** (Passaic County) — Resolution #24 (page 396)

The committee *recommends* that this resolution be approved.

Adopted

The chairman wishes to express his thanks to the members of Reference Committee "C", especially for their patience and even tempers. I wish to thank all who participated in the discussion. I am particularly grateful to the Trustees and Fellows of the Society who attended this reference committee and aided the committee so much.

Report as a whole adopted

Reference Committee "D"

Robert E. Verdon, M.D., Chairman

Reference Committee "D" met on Sunday, May 14, 1967, with all members present: Doctors Elmer L. Grimes, Henry L. Hermann, Roy T. Forsberg, Lloyd A. Hamilton, and the chairman. Approximately 15 delegates and members were present to discuss the various items under consideration.

1. **Medical Defense and Insurance** (page 320) – and **supplemental** (page 324)

The reference committee was informed that recommendation #2 of the report of the Committee on Medical Defense and Insurance should be amended to read:

That the E. & W. Blanksteen Agency be continued as the official broker for our accident and health, *life insurance, high-limit accident,* and major medical programs.

The reference committee *recommends* that the annual report of the committee, as amended, and the supplementary report be approved.

Adopted

2. **Medical Education** (page 325)

In the reference committee hearings, it was brought out that at its April meeting the Board of Trustees approved the distribution to the membership of a questionnaire prepared and submitted by the Committee on Medical Education to ascertain why members do or do not attend postgraduate educational meetings and to solicit constructive suggestions. The reference committee was also informed that the Board of Trustees received the committee's (Medical Education) recommendations concerning the Millis Report and "Meeting the Challenge of Family Practice" (ad hoc committee) and had referred them to the AMA delegates for study and action at the AMA meeting.

It was brought out during the hearing that one of the medical educators, at a recent meeting, stated that the medical schools do not discourage students from entering general practice. It is the *recommendation* of this reference committe that medical students in New Jersey schools be given exposure to, and contact with, family doctors.

Adopted

Recently, the Committee on Medical Education met with the Dean of Rutgers Medical School and the President of New Jersey College of Medicine and Dentistry, this being the first formal liaison contact meeting on the part of the committee. It is the hope of this reference committee that this contact will be continuing and effective. It is *recommended* by this reference committee that all interested groups of this Society should communicate, through the Committee on Medical Education, any of its concerns relative to the medical and dental schools.

Adopted

The establishment of liaison contact with the medical schools is a significant accomplishment, and the Committee on Medical Education is to be commended.

3. **Medicine and Religion** (page 362)

The committee *recommends* approval of this report.

Adopted

4. **Retirement Plan for Physicians** (page 363)

The committee *recommends* approval of this report.

Adopted

5. **Resolutions:**

a. **Group Automobile Insurance Coverage** (Essex County) — Resolution #5 (page 381)

The committee feels that this resolution has merit and *recommends* its adoption.

Adopted

b. **Retirement Plan for Physicians** (Mercer County) — Resolution #21 (pages 393)

The committee feels that this resolution calls for action already being dealt with by the committee, as reflected in its annual report. Therefore, your committee regards this resolution as redundant and unnecessary and *recommends* that it not be adopted.

Adopted

c. **Medical-Dental School for South Jersey** (Camden County) — Resolution #23 (page 395)

The committee notes that the House of Delegates has previously recorded itself as favoring the establishment of a third medical school. It seems that the Camden area has the facilities necessary for the establishment of such a school. Therefore, the committee *recommends* the adoption of this resolution.

Adopted

I wish to thank the members of the reference committee and all who appeared before it.

Report as a whole adopted

Reference Committee "E"

Edward Foord, M.D., Chairman

Reference Committee "E" met on Sunday, May 14, 1967, with all members present: Doctors John P. O'Connor, Irving Chrisman, John A. Kinczel, Robert G. Stineman, and the chairman. Thirty delegates attended this committee meeting. The meeting was also attended by Dr. E. Tremain Bradley, President of the Connecticut Medical Society and guest of MSNJ; Richard I. Nevin, Executive Director; and E. Powers Mincher, Legislative Analyst to the Society's Council on Legislation.

1. **Legislation** (page 337) — and supplemental (page 343)

The committee reviewed the annual and supplemental reports of the Council on Legislation. The committee, approving both, commends the Council for its activities and endeavors throughout the year.

The reference committee *recommends* that the reports be approved.

Adopted

2. **Public Relations** (page 348)

The committee also considered and voted unanimously to accept the report of the Council on Public Relations. The committee commends the Council for its activities and endeavors throughout the year.

The reference committee *recommends* that the report be approved.

Adopted

3. **Resolutions:**

The committee, in deliberating on the resolutions submitted to it, was guided not only by its own opinions but also by the advice of the Legislative Analyst to the Council on Legislation, Mr. E. Powers Mincher. Resolutions which were altered were done so with the consent of their proponents, to add clarity and impact, in order to bring about their intended result.

a. **Annual Awards for News Reporting of Medical Topics** (Burlington County)—Resolution #6 (page 382)

The committee considered this resolution in detail. While the reference committee takes no exception to the intent, language, or provisions of this resolution, it questions whether or not — in light of AMA activities in this field — such a resolution is truly necessary for New Jersey.

Therefore, the reference committee *recommends* that Resolution #6 be not adopted.

Adopted

b. **Chiropractic as an Unscientific Cult** (Bergen County) — Resolution #7 (page 383)

c. **Medical Ancillary Personnel** (Passaic County) — Resolution #8 (page 383)

Resolutions #7 and #8 were discussed in detail. Extensive and prolonged discussion was involved in consideration of these resolutions. All discussants were clearly in favor of the general intent of the resolutions, but many were concerned about the manner in which they would be implemented. Sponsors of both these resolutions indicated they were favorably disposed to their being merged into one resolution which cited the need for a review of all statutes relating to the practice of medicine and surgery in this State by a committee appointed by the President. Accordingly, the following resolution is submitted in substitution for Resolutions #7 and #8:

SUBSTITUTE RESOLUTION
for Resolutions #7 and #8

Whereas, Title 45, Chapter 9 of the Revised Statutes of New Jersey governing the practice of medicine and surgery is based for the most part upon statutes enacted at the turn of the century; and,

Whereas, these statutes have become outmoded by technilogical developments, federal legislation, and reorganization of state government; and

Whereas, the existing statutes adversely affect the public welfare; now therefore be it

RESOLVED, that a committee be appointed by the President of The Medical Society of New Jersey to review all statutes related to the practice of medicine and surgery in this State and to submit specific recommendations for their revision to the Board of Trustees as quickly as possible.

Adopted

d. **Prohibition of Advertisements and Solicitation by Practitioners of the Healing Arts** (Monmouth County) — Resolution #22 (page 394)

The committee also considered this resolution. It was felt that clarification by means of rewording would be most helpful in carrying the impact of this resolution. The following substitute resolution is submitted for your consideration:

SUBSTITUTE RESOLUTION
for Resolution #22

Whereas, use of any media to advertise or to solicit patients by—or on behalf of—any healing art or its practitioners violates accepted

standards of ethical conduct and professional deportment; and,

Whereas, such advertising impairs the stature of the healing arts in the eyes of patients, colleagues, members of allied professions, and the general public alike; and,

Whereas, such advertising is frequently misleading, to the detriment of public health; now therefore be it

RESOLVED, that The Medical Society of New Jersey draft appropriate legislation prohibiting such advertising; and in cooperation with other groups of practitioners, arrange for the introduction of such legislation.

Adopted

e. **Seat Belts in Public Conveyances** (Middlesex County) — Resolution #25 (page 396)

The reference committee wishes to submit the following reworded resolution as a substitute for the one originally submitted:

SUBSTITUTE RESOLUTION
for Resolution #25

Whereas, it has been established that vehicular seat belts reduce the incidence of accidental death and disability when properly installed and utilized; and

Whereas, the medical profession should support measures designed to promote the public safety; now therefore be it

RESOLVED, that The Medical Society of New Jersey urge the legislature of the State of New Jersey to pass legislation providing for mandatory installation of seat belts in public conveyances.

Adopted

f. **New Legislation Relative to Diagnostic and Therapeutic Approaches on Minors with Suspected or Proved Venereal Disease** (John Winslow, M.D., Delegate from Essex County) — Resolution #26 (page 397)

The reference committee respectfully submits the following substitute resolution for your consideration:

SUBSTITUTE RESOLUTION
for Resolution #26

Whereas, in New Jersey venereal disease among minors is of epidemic proportions; and

Whereas, this daily growing epidemic constitutes a present menace to the public health and to the economy of the State; and

Whereas, a physician may not treat a minor without parental consent; and

Whereas, experience has proved that minors ill, or suspected of being ill, or infected with venereal disease are unwilling to seek or secure parental consent prior to requesting physicians' services for the treatment of this disease; and,

Whereas, the initial treatment by a physician may render veneral disease non-communicable; and

Whereas, control of venereal disease can be effected quickly by rendering it non-communicable; now therefore be it

RESOLVED, that The Medical Society of New Jersey memorialize the legislature of the State of New Jersey to pass and the Governor to approve, legislation empowering physicians to treat minors ill, or suspected of being ill, with venereal disease without first securing parental consent.

Adopted

g. **Repeal of Gross Receipts Tax on Unincorporated Business** (Howard H. Lehr, M.D. and Henry J. Mineur, M.D., Delegates from Union County) — Resolution #27 (page 397)

The reference committee submits this amended resolution:

Whereas, Chapter 137, P.L. 1966 imposes a

discriminatory gross receipts tax on unincorporated businesses; and

Whereas, all gross receipts taxes are, by their nature, unjust and do not reflect ability to pay; and

Whereas, experience indicates that a tax of a quarter of 1% is only a start; now therefore be it

RESOLVED, that the New Jersey Legislature be urged to repeal Chapter 137, P.L. 1966.

Adopted

The chairman wishes to thank the members of the committee for their diligence and conscientiousness in considering item by item all of the matters that came before it in this session. He would also like to thank the members and delegates for attending this reference committee meeting and offering their opinions in its deliberations, and most especially to express his thanks to Mr. Mincher, the Legislative Analyst, for his guidance in considering and rephrasing the resolutions submitted.

Report as a whole adopted

Reference Committee "F"

Charles L. Cunniff, M.D., Chairman

Reference Committee "F" met on Sunday, May 14, 1967, with all members present: Doctors Eugene J. Tyrrell, Seymour F. Kuvin, Walter E. Corrigan, Isaac N. Patterson, and the chairman. Approximately 45 delegates and members were present to discuss the various items under consideration.

1. **Board of Trustees — Items**

a. **New Coverage for over 65 Welfare Recipients** (page 304)

The reference committee *recommends* approval of this report as submitted. We wish to draw attention to the stated fact that "there is no commitment to extend the terms of this proposal to the implementation of Title XIX."

We also feel it should be noted that the discussion brought out the fact that if the physician puts the welfare number of the patient on his bills, it will expedite proper payment by the carrier.

Adopted

b. **Health Facilities Planning Council** (page 304)

The committee *recommends* approval of the report.

Adopted

2. **Medical Services** (page 350)

The reference committee reviewed the various items submitted in the regular and supplementary reports of the Council on Medical Services.

Regarding Resolution #15 (1966 House of Delegates), we urge continued study on the problem of separation of professional fees and hospital charges.

We also reiterate previous recommendations that physicians' narcotic registration numbers *not* be imprinted on prescription pads.

We commend the Council for a difficult job well done, and we *recommend* approval of the reports.

Adopted

3. **Chronically Ill and the Aging** (page 354)

The committee *recommends* approval of this report.

Adopted

4. **Occupational Health, Workmen's Compensation, and Rehabilitation** (page 353)

We wish to record strong concurrence with the recommended policy "That the physician is entitled to his usual and customary fee whether his services are rendered to state employees or to private patients." We also agree with the recommendation "that MSNJ request the Governor to appoint a representative from the Special Committee on Occupational Health, Workmen's Compensation, and Rehabilitation to the Workmen's Compensation Commission."

The committee *recommends* approval of this report.

Adopted

5. **Resolutions:**

a. **Generic Versus Proprietary Drugs** (Essex County) — Resolution #9 (page 384)

Your committee *recommends* approval of this resolution.

Adopted

b. **Retention of Provision under Part B Medicare Excluding Payments of Interns and Residents** (Nathan J. Plavin, M.D., Delegate from Hudson County) — Resolution #10 (page 385)

The committee approves the intent of this resolution. With the permission of the sponsor we *recommend* the following amended version:

RESOLVED, that MSNJ reaffirm its support of the principle presently embodied in the Medicare Law (Title 18) of payment for the costs of medical services to fully licensed physicians freely chosen by the beneficiaries, and of exclusion of payments under Part B to interns and residents; and be it further

RESOLVED, that this resolution be submitted to the House of Delegates of the AMA and that our AMA Delegates do all in their power to obtain its adoption at the National level.

Your reference committee *recommends* adoption of Resolution #10 as amended.

Adopted

c. **Title XIX Medical Assistance Program** (Essex County) — Resolution #11 (page 386)

This resolution was discussed at considerable length by many members and delegates and in conjunction with discussion of the supplementary report of the Council on Medical Services on Title XIX.

Your reference committee agrees fully with the intent of the resolution, and with the agreement of the sponsors, it *recommends* rewording of the second "resolved" as follows:

RESOLVED, that MSNJ attempt to have the following four parts included in the Title XIX Plan:

(1) Assure the beneficiary of free choice of physician and hospital;

(2) Provide payment of the physician's services on the basis of his usual and customary fees

(3) Work for the designation of a qualified insurance carrier to handle claims and payment of charges for medical services; and

(4) Permit billing to the beneficiary, or to the agency or carrier, on the basis of usual and customary fees, without requiring assignment from the patient.

Your reference committee *recommends* adoption of Resolution #11 as amended.

Adopted

d. **Utilization Review Committee Immunity** (Essex County) — Resolution #12 (page 387)

The committee recommends approval of Resolution #12, with the "resolved" amended to read:

RESOLVED, that The Medical Society of New Jersey be urged to seek the passage of State legislation which would provide a physician who serves on *any* utilization review committee immunity from litigation arising from the actions of the committee.

Adopted

e. **Insurance Coverage for State-Subsidized Patients** (Morris County) — Resolution #18 (page 391)

Your committee *recommends* approval of this resolution as submitted.

Adopted

Report as a whole adopted

Reference Committee "G"

Frank M. Galioto, M.D., Chairman

Reference Committee "G" met on Sunday, May 14, 1967, with all members present: Doctors Francis A. Pflum, I. Edward Ornaf, Thomas F. McLaughlin, William A. Dwyer, Jr., and the chairman. Approximately 23 delegates and members were present to discuss the various items under consideration.

1. **Board of Trustees** — Items

a. **Consultations by Physicians in Partnership** (page 305)

The committee *recommends* approval of this report.

Adopted

b. **External Cardiopulmonary Resuscitation** (page 306)

The committee *recommends* approval of the section dealing with External Cardiopulmonary Resuscitation Including Defibrillation and the Registered Professional Nurse.

Adopted

Your reference committee *recommends* that the section dealing with External Cardiopulmonary Resuscitation for Properly Qualified Non-Professional Personnel be approved, but further *recommends* that the State Department of Health be encouraged to broaden and expand the instruction and examination mechanisms so as to increase the number of properly qualified non-professional personnel.

Adopted

c. **Heart Disease, Cancer and Stroke** (page 306)

The committee *recommends* approval of this report.

Adopted

d. **Mixing of Obstetrical/Gynecological Patients** (page 307)

The committee *recommends* approval of this report.

Adopted

2. **Public Health** (page 355)

Boxing Regulations

The committee *recommends* that the report be approved with the addition of the following requirement: that the minimum age for boxing be 16.

Adopted

3. **Air Pollution Control** (page 356)

The committee *recommends* approval of this report.

Adopted

4. **Cancer Control** (page 357)

The committee *recommends* that the report be approved as amended (amended portion italicized):

That the Cancer Control Committee survey all general hospitals licensed by the State of New Jersey to determine how many cancer and tumor registries are active.

That physicians and surgeons on hospital staffs encourage and utilize the hospital cancer program, *including registries,* so that more programs will meet the standard of the American College of Surgeons.

Adopted

5. **Child Health** (page 357)

Boxing by Minors

In view of the recommendation already made in this area of concern under the report of the Council on Public Health, your committee *recommends* that this section of the report be approved as informative.

Adopted

Little League Football Hazards, Child Safety, Measles Vaccine, School Physicians:

Your committee *recommends* that these sections of the report be approved.

Adopted

6. **Conservation of Vision** (page 358)

a. **Eye Health Screening Program**

The committee *recommends* approval of this section of the report.

Adopted

b. **Resolution #8 — 1966 House of Delegates**

The committee *recommends* that this section of the report be approved.

Adopted

c. **Amblyopia Detection Program**

Your reference committee *recommends* that this section of the report be approved with the stipulation that MSNJ retain an authoritative voice in the direction and control of these screening programs.

Adopted

7. **Maternal and Infant Welfare** (page 359)

The committee *recommends* approval of this report.

Adopted

8. **Mental Health** (pages 307, 332, 360)

The committee *recommends* approval of this report.

Adopted

9. **Resolution:**

a. **Community Mental Health Centers** (Passaic County) — Resolution #13 (page 388)

The committee recommends approval of the following amended version of the resolution. The amended version has the approval of the sponsor of the original resolution.

Whereas, it has been recognized that the medical profession which has medical, legal, and moral responsibilities (and the Psychiatric specialty within that profession) is the appropriate profession to be delegated the responsibility of treating mentally ill individuals; and

Whereas, it has been recognized that the medical profession has the medical, legal, and moral responsibilities for treating mentally ill individuals; and

Whereas, it has been recognized that "somatic" and "mental" symptoms may be facets of one and the same illness, and that there is an inter-relationship between somatic and psychic processes; and

Whereas, it is, therefore, incumbent of the medical profession to be involved maximally in the planning and implementation of Community Mental Health Services; and

Whereas, it follows, that Community Mental Health Centers should be under medical — preferably psychiatric—leadership; now therefore be it

RESOLVED, that each general hospital be encouraged to provide specific in-patient facilities for treatment of acutely mentally ill patients, whether the onset of the patients' overt "mental" illnesses occurs in the course of their hospital treatment for "somatic" illness, or, occurs while they are in the community, and be it further

RESOLVED, that a general hospital should be the nucleus of a Community Mental Health Center.

Adopted as amended

Report as a whole, as amended, adopted

To Bombay Next February

Here's your chance to make a trip (for your own graduate education and professional development) to fabulous Bombay. From February 17 to February 21, 1968, The Pacific Area Congress Against Rheumatism will meet in India to review what is new in the diagnosis and management of rheumatic diseases. If you have a paper you would like to read in India (you may read it in English; it is not necessary to speak Hindi or even Panjabi), send it, before September 15 this year to the address below. Even if you don't have a paper to present, you might want to learn about rheumatic diseases. For more information, write to Dr. M. D. Desai, Indian Rheumatism Association, Fateh Manzil, 457 Lamington Road, Bombay 4 India. (Aerograms now cost 13¢ and air-mail letters 20¢.)

Reference Committee "H"

Joseph M. Gannon, M.D., Chairman

Reference Committee "H" met on Sunday, May 14, 1967 with all members present: Doctors John B. Fuhrmann, Nathan J. Plavin, Frank W. Konzelmann, Charles O. Tyler, and the chairman. Fifteen delegates and members were present to discuss the various items under consideration.

1. **Annual Meeting** (page 313)

The report of the Committee on Annual Meeting was considered in detail. This committee, together with the related Subcommittees on Scientific Exhibits and Scientific Program, is to be commended for its efforts in this undertaking.

The committee *recommends* approval of this report.

Adopted

2. **Scientific Exhibits** (page 315)

The committee *recommends* approval of this report.

Adopted

3. **Scientific Program** (page 315)

The committee *recommends* approval of this report.

Adopted

4. **Emergency Medical Care** (page 361)

The report of the Committee on Emergency Medical Care, including its specific recommendations regarding road signs indicating hospital locations, a recommendation concerning training physicians in emergency care, emergency highway telephones, a recommendation of a model "ordinance for ambulance service," and a recommendation that component societies join in the training of ambulance attendants, was favorably received.

The committee *recommends* approval of this report.

Adopted

5. **Honorary Membership** (page 316)

The Committee on Honorary Membership reported that no nominations had been received this year.

The committee *recommends* acceptance of this report.

Adopted

6. **Nursing Education and Recruitment** (page 362)

The report of the Committee on Nursing Education and Recruitment was favorably received. The reference committee held the opinion that while the inauguration of college-based nursing training courses in New Jersey is to be commended, such a program obviously will take 10 to 20 years before its full impact can be attained and evaluated. In the meantime, this new trend should not be permitted to be used as an excuse or reason to diminish or discourage the hospital diploma program for nurses' training.

The committee *recommends* approval of this report.

Adopted

7. **Traffic Safety** (page 364)

The report of the Committee on Traffic Safety was considered favorably, including its recommendation that Assembly Bill 292 (which appears to require a complete physical examina-

tion of each driver by a licensed physician) be *disapproved* as its intent is unclear and impractical in terms of fulfillment.

The committee *recommends* approval of this report.

Adopted

8. **Woman's Auxiliary Advisory** (page 331)

The report of the Advisory Committee to the Woman's Auxiliary was favorably considered as written. In regard to the request of the Woman's Auxiliary for permission to support MSNJ and its component societies in a proposed program to combat venereal disease, the reference committee felt that at this time the program lacks preciseness and it was uncertain as to possible costs for implementation. It nevertheless decided to accept the report as a progress report without specific recommendation.

The committee *recommends* approval of this report.

Adopted

9. **Nominations for Emeritus Membership** (page 378) and supplemental

The report of the Committee on Nominations for Emeritus Membership, together with the supplemental report, was approved.

Adopted

10. **Resolutions:**

a. **Change in Convention Format** (Essex County) — Resolution #14 (page 389))

Even though the reference committee did not look with favor on this resolution, nevertheless in the interest of intent (inasmuch as MSNJ is committed to the present convention format at least through 1970), Resolution #14 is, with the approval of delegates from Essex County attending the reference committee meeting, amended to read:

RESOLVED, that *at the earliest date possible* the convention format of The Medical Society of New Jersey be changed so that the first session of the House of Delegates would start on either Wednesday or Thursday, and the third session would fall on Sunday when most delegates can take part in decision of policy.

As noted above, the reference committee did not look with favor on this resolution. It was its considered opinion that the percentage of attendance at the third session would not change favorably with a change of the day of the week (and indeed might decrease), that the problems of leaving Atlantic City on a Sunday might well prove more formidable than those encountered on a weekday, that the scheduling of reference committees for Friday morning with elections on Friday afternoon might stimulate a general exodus of delegates the same day, and that sufficient advance notice now exists so that each delegate can effectively plan for his attendance under the present format.

The reference committee recommends *disapproval* of this resolution.

Adopted

b. **Section on Plastic and Reconstructive Surgery** (MSNJ Board of Trustees) — Resolution #15 (page 389)

After much discussion of this resolution which would create a Scientific Section on Plastic and Reconstructive Surgery at the annual meeting, the reference committee considered that this branch should continue to present its program as part of the Section on Surgery. Attention is invited to the fact that the trend at our annual meetings is to combine Sections for the Scientific Sessions rather than to fragment existing ones.

The reference committee *recommends* disapproval of this resolution.

Rejected

Report as a whole, as amended, adopted

Reference Committee On Constitution And Bylaws

Theodore K. Graham, M.D., Chairman

Reference Committee on Constitution and Bylaws met on Sunday, May 14, 1967, with all members present: Doctors Josiah C. McCracken, Jr., Henry J. Mineur, Harold L. Colburn, Jr., Raymond A. McCormack, and the chairman. Approximately 25 delegates and members were present to discuss the various items under consideration.

1. **Council on Mental Health** (page 307 and 332)

The reference committee *recommends* approval of this section of the report of the Board of Trustees (page 307) as well as the amendment proposed by the Committee on Revision of Constitution and Bylaws (page 332 and 334).

Adopted

2. **Emeritus Membership** (page 333)

The reference committee *recommends* approval of that section of the report of the Committee on Revision of Constitution and Bylaws dealing with this item.

Adopted

3. **Associate Membership** (page 334)

The reference committee *recommends* approval of that section of the report of the Committee on Revision of Constitution and Bylaws dealing with this item.

Adopted

4. **Representation on Board of Trustees and Nominating Committee**

a. **Procedure of Election** — from Board of Trustees (page 307) recommendations of ad hoc study committee

b. **Reapportionment of Representation on Board of Trustees**

(1) Amendment from Board of Trustees (pages 332 and 335)

(2) Resolution #17 from Bergen County (page 390)

c. **Reapportionment of Representation on Nominating Committee**

Amendment from Essex County (pages 333 and 336)

Proportional representation on both the Board of Trustees and the Nominating Committee was discussed at the same time. There was much division of opinion and extended discussion.

The Board of Trustees proposed Amendment to the Constitution (pages 332 and 335) — based upon the recommendations of the ad hoc study committee — urges that each judicial district be represented by two trustees for a membership up to 1,000; and that each judicial district be entitled to one additional trustee for each additional 1,000 members, or major fraction thereof, computed as of December 31.

Resolution #17 from Bergen County Medical Society (page 390) proposes that each judicial district be represented by one trustee for each 500 members, or major fraction thereof.

Under the Board amendment, the First District would be entitled to 4 trustees; the Second District, 3 trustees; the Third, Fourth, and Fifth Districts, 2 trustees each.

Under the proposal in Resolution #17 from Bergen County, the First District would be entitled to 5 trustees; the Second District, 4

trustees; the Third and Fourth Districts, 2 trustees each; and the Fifth District, 1 trustee.

The reference committee gave due consideration to the forceful remarks made in support of Bergen County's proposal by representatives from Bergen, Essex, Morris, Passaic, and Union Counties.

The committee weighed the merits of both proposals as presented and was unanimous in its agreement that the recommendations of the ad hoc study committee — approved by the Board of Trustees and subsequently by the Committee on Revision of Constitution and Bylaws — were the more feasible and desirable in determining representation on the Board of Trustees. They are:

(1) That the office of "11th trustee" be discontinued, upon expiration of the term of the incumbent.

(2) That each judicial district be represented by two trustees for a membership up to 1,000 and that each judicial district be entitled to one additional trustee for each additional 1,000 members or major fraction thereof.

Therefore, your reference committee *recommends:*

(1) That the amendment to the Constitution, Article VI, proposed by the Board of Trustees (page 335) be approved.

(2) That Resolution #17 from the Bergen County Medical Society (page 390) be disapproved.

Adopted

The reference committee was unanimous in supporting the conclusions of the ad hoc study committee concerning reapportionment of the Nominating Committee proposed by Union County in 1966, with which the proposed amendment submitted by Essex County this year is identical (page 308).

The reference committee considered in this connection the report of the Committee on Revision of Constitution and Bylaws dealing with the amendments from Essex County and agreed to support that report (page 333).

Your reference committee, therefore, *recommends* that the amendment proposed by the Essex County Medical Society to reapportion the Nominating Committee (page 333) be not adopted.

Adopted

It was the opinion of the reference committee that some procedure might be evolved that would give more equitable representation to populous counties on the Nominating Committe without "weight voting" by one person.

It is for this reason that your reference committee *recommends* that the entire matter of reapportionment of representation on the Nominating Committee be returned to — and studied in depth by — the Committee on Revision of Constitution and Bylaws, for subsequent report to the House.

Adopted

5. **Resolution #16 from Morris County Medical Society** (page 390)

The intent of Resolution #16 — to abolish the office of "11th trustee" — has already been accomplished in the amendment proposed by the Board of Trustees.

In view of the reference committee's recommendation to approve the Board's proposal, the committee *recommends* that no action be taken on Resolution #16.

Adopted

Report as a whole adopted

Report of Nominating Committee and Election—May 14, 1967

John J. Bedrick, M.D., Chairman

OFFICE	TERM	ELECTED
President-Elect	1 year	John F. Kustrup, M.D., Trenton
1st Vice-President	1 year	Nicholas A. Bertha, M.D., Wharton
2nd Vice-President	1 year	Emanuel M. Satulsky, M.D., Elizabeth
Secretary	1 year	Marcus H. Greifinger, M.D., Newark
Treasurer	1 year	Samuel J. Lloyd, M.D., Trenton
Trustees:		
1st District	3 years	Francis J. Benz, M.D., Chatham
3rd District	2 years*	David Eckstein, M.D., Trenton
4th District	3 years	Louis F. Albright, M.D., Spring Lake
5th District	3 years	A. Guy Campo, M.D., Westville
11th Trustee	2 years*	Sherman Garrison, M.D., Bridgeton
Judicial Councilors:		
3rd District	3 years	Albert F. Moriconi, M.D., Trenton
AMA Delegates:	2 years	Joseph P. Donnelly, M.D., Jersey City
	2 years	Jesse McCall, M.D., Newton
	2 years	Isaac N. Patterson, M.D., Westville
AMA Alternative-Delegates:	2 years	Joseph R. Jehl, M.D., Clifton
	2 years	Robert E. Verdon, M.D., Cliffside Park
	2 years	Louis S. Wegryn, M.D., Elizabeth
	1 year*	John J. Bedrick, M.D., Bayonne
Delegates and Alternates to Other States:		
New York:		
Delegate	1 year	Joseph P. Donnelly, M.D., Jersey City
Alternate	1 year	John W. Holland, M.D., Margate
Connecticut:		
Delegate	1 year	Lloyd A. Hamilton, M.D., Lambertville
Alternate	1 year	Frank W. Konzelmann, M.D., Somers Point
Administrative Councils:		
Legislation:		
1st District	1 year*	S. William Kalb, M.D., Newark
2nd District	3 years	Louis Kosminsky, M.D., West New York
3rd District	3 years	Leonard Rosenfeld, M.D., Ringoes
Medical Services:		
2nd District	3 years	Leonard Brown, M.D., Hackensack
3rd District	3 years	Karl T. Franzoni, M.D., Trenton
Mental Health:		
1st District	1 year	Henry A. Davidson, M.D., Cedar Grove
2nd District	1 year	Eugene V. Resnick, M.D., Paramus
3rd District	2 years	Robert S. Garber, M.D., Belle Mead
4th District	3 years	Edward A. Schauer, M.D., Farmingdale
5th District	3 years	Miles E. Drake, M.D., Vineland
6th Member	2 years	Evelyn P. Ivey, M.D., Morristown
Public Health:		
2nd District	3 years	Kendrick P. Lance, M.D., Patterson
3rd District	3 years	Philip J. Kunderman, M.D., New Brunswick
5th District	2 years*	Robert G. Salasin, M.D., Wildwood
Public Relations:		
3rd District	3 years	Howard D. Slobodien, M.D., Perth Amboy
4th District	1 year*	John P. Kengeter, M.D., Toms River
6th Member	3 years	Edward Foord, M.D., Burlington
Standing Committees:		
Annual Meeting	1 year*	James A. Rogers, M.D., Paterson
	3 years	Peter H. Marvel, M.D., Northfield
Finance and Budget	3 years	John S. Van Mater, M.D., New Brunswick
Medical Defense and Insurance	3 years	Jerome G. Kaufman, M.D., Maplewood
Medical Education	3 years	John W. Nicholson, III, M.D., Moorestown
Publication	3 years	C. Spencer Davision, M.D., Salem
Woman's Auxiliary Advisory	3 years	Edward M. Coe, M.D., Cranford

Adopted as amended: Dr. William J. D'Elia of Neptune was nominated from the floor—and elected by the House—for a three-year term on the Committee on Medical Defense and Insurance (instead of Dr. Jerome G. Kaufman of Maplewood). All other nominees were elected to the designated offices for the terms indicated.

* Elected to fill unexpired terms

GENERAL SESSION

Sunday Afternoon, May 14, 1967

The General Session on Medicare convened at 3:00 p.m.

Symposium On Present Status And Recent Developments Under Medicare

Presiding—Joseph R. Jehl, M.D., President

Medicare In The Sixties
Thomas G. Bell, Ph.D., Assistant Bureau Director, Bureau of Health Insurance, Social Security Administration, Baltimore, Maryland

Moderator
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Panelists
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Thomas J. Beatty, Manager, Medicare Part B, Millville Office, Prudential Insurance Company

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President Jehl: As you well recognize, this has been a rather unusual year because of the great change which has taken place in our society. I don't mean The Medical Society of New Jersey; I mean the society of the United States. The problems which have developed have been numerous. The problems which are going to develop may be more numerous. In an attempt for us to all appreciate these problems, we have arranged this panel, which will enable you to understand some of the problems which beset the fiscal agent, some of the problems which become questions in your understanding and appreciation of the problems of Medicare.

I'm now going to turn the meeting over to Mr. White. Mr. White is a friend of many of us. He is an experienced executive in the Prudential Insurance Company. We have met with him before and he has been an important agent in the implementation of these programs. We have all been impressed with his understanding of the problem and his effective handling of some of the situations. Well, I suppose, we are now greeting this afternoon his majesty's opposition — Mr. White.

(Applause)

The Moderator: Thank you, Dr. Jehl.

One year ago I stood before you to take a look at Medicare prospectively. At that time there were many doubts in the minds of both the audience and the speaker as to what Medicare would hold for us after July 1, 1966. Now after ten months of operation we'd like to look at Medicare retrospectively, see what has gone on, and try to work out with you the answers to some of the problems we have encountered.

The way we intend to operate today is this: We will have a speaker who will discuss Medicare in the Sixties. Following that he will join the rest of us on the panel. We intend to discuss informally among the panel members some of the important points we think you might like to hear about. Following that we'll throw the discussion open to questions from the floor.

I am very pleased to present our speaker today because I have had the good fortune to work with him during the past year. I've been a member of a group representing the carriers working with the Social Security Administration on rules, regulations, processing systems, and so forth, and he is, of course, active in that field, and I have been working with him closely.

Tom Bell received his bachelor's degree from Los Angeles State College in 1952, his doctorate in public administration from the University of Southern California in 1965. He served for ten years as a County Welfare Director in California and as Colorado State Director of Public Welfare for two years, prior to joining the Social Security Administration in June of 1966 as Assistant Director, Bureau of Health Insurance, Social

Security Administration. Dr. Bell is going to talk to you today on Medicare in the Sixties.

(Applause)

Dr. Thomas G. Bell: Thank you, Bill White.

I appreciate the opportunity to appear before you on this panel with Dr. Bernstein, Bill White, Ev Park, Tom Beatty and George Garver. It is organizations such as these gentlemen represent whose continuing concern with health care has, in part, been responsible for many of the gains made to date in the administration of health insurance programs. This opportunity to exchange ideas and opinions — regardless of how divergent the individual points of view — facilitates solutions to problems that challenge each of us in our own field of particular interest.

The American public has come to expect the highest quality in their health care. To fulfill this expectation, there must be a full partnership of all of us. For any partnership to function, we need to maintain this continued exchange of ideas and opinions.

The delivery of health care under our voluntary system is not static, nor should it be. The professional members of the medical community are constantly seeking, and finding, better weapons in man's age-old fight against disease and infirmity. But the professional medical practitioner does not function in a vacuum, independent of all other components of the community.

Represented on this panel are three distinct and separate areas concerned with the financing of health care. Mr. White, and his excellent staff, speaking for The Prudential Insurance Company of America, acts, to some degree, as a trustee or representative of consumers. These consumers pay his organization their premium dollars so that they may meet the cost of their medical care. Neither Mr. White nor his organization maintains any pretense of providing health care. Their primary concern is to pay the cost of such care from funds that have been entrusted to them by their members. Trustee-representatives, like the Prudential, are charged with the responsibility of representing the best interests of those consumers of health care who can purchase such care from their own resources. Health insurers have a major and direct role to play through sound contract design and effective claims administration. By the close of 1966, an estimated 159 million persons in this county — 82 per cent of the civilian population — had some form of voluntary health insurance. These insurance plans varied widely in scope of benefits and services covered.

Another area is represented by Dr. Bernstein, Medical Director of the Division of Public Welfare of the New Jersey State Department of Institutions and Agencies. His primary concern is for those who, for a variety of reasons, are unable to purchase health care from their own resources. Despite the fact that the medical profession has long furnished its skills to this part of our population without regard to their ability to pay, modern health care now involves many components which fall outside of the physician's individual charity.

As a representative of the Bureau of Health Insurance, charged with the administration of the Health Insurance for the Aged Act — more commonly called Medicare — I have a primary concern with the financing of high-quality medical care, under insurance principles, for still another part of our population — the approximately one-tenth of our people who have attained the age of 65 years.

Each of us represents a particular area of concern, or, if you will, the financing of health care for a particular segment of the population and under different modes of financing. But none of us works independently of the other. It was primarily due to the long experience gained by Prudential, in its function as trustee-representative of the premium-paying public, that this organization was chosen by both the State Department of Institutions and Agencies and the Federal Bureau of Health Insurance to process claims for medical services to final payment.

But any arrangement for the financing of health care, that might be developed between Dr. Bernstein, Mr. White, and me would be completely meaningless without the cooperation of the medical profession. You doctors are the only ones who can deliver one iota of health care. Without the participation of the medical profession in this partnership, all of the plans that the three of us might devise would be totally ineffective against the rising demand of the American public for quality health care. Fortunately for the Medicare program, the medical profession has taken an increasingly active part in the operation of the program. To quote from Dr. Charles Hudson, President of the AMA, from his testimony before the House Ways and Means Committee on the fourth of last month, "While Medicare was still a legislative proposal, we vigorously opposed it. As individual physicians and as an association, we did not and do not believe in the principle it represents. However, once it became the law of our land, the AMA worked just as vigorously to make it operate as well as possible."

And now that Medicare has become law, let me discuss briefly some of the problems inherent in its administration.

One such area has been in the provision for outpatient hospital services, most particularly the diagnostic service coverage under the hospital insurance part of the program. The intent of this inclusion was certainly desirable. It was based on the well-founded theory that diagnostic work-ups as a covered service would relieve some of the pressure for admitting patients for these same services when they could be handled just as well on an out-patient basis. As written into law, the provision has presented unforeseen administrative problems which have been almost unworkable. The hospital has to hold a claim open for twenty days, file a claim for credit against the patient's calendar year medical insurance deductible, whether payment was due or not, and separate out the physician's component for the services. The Social Security Administration has recommended to the Congress that all outpatient coverage be placed under medical insurance. This, in effect, involves both the hospital and the patient with only the $50 calendar year deductible. Then, claims can be filed as they occur without holding for completion of a 20-day period. The inpatient diagnostic services would be covered by a new Part C with no deductible other than the $40 hospital costs. To give you some indication of the extensive effect of this outpatient level of care, we have already received over 2.25 million bills for such services.

Another area that has created some problems in the claims process for medical insurance has been the requirement for itemized and receipted bills when no assignment is taken. Without exception, the carriers tell us that their claims process is significantly speeded up when the physician uses the regular claim form in lieu of an itemized receipted bill, whether an assignment is accepted or not. The same information is required on either the claim form or the itemized receipted bill. Almost half the medicare beneficiaries are past 70 and a claim form that is simple to the doctor's office assistant might appear very difficult to many of these people. Completion of the claim form in lieu of the receipted bill could be of very real service to both you, your patient, and Prudential in the processing of Medicare claims. Let me assure you that use of this claim form, which was developed in consultation with the American Medical Association, in no way obligates the individual physician who does not choose to accept assignment. It simply lets one piece of paper that has to be sent to the carrier in any event serve in place of two or more.

Other areas in which legislation has been suggested to the Congress, include that of certification at time of admission. This turned out to be a problem that no one really anticipated. As we interpreted the intent of Congress, this initial certification was to be a very simple statement, kept on file by the hospital, as a proper documentation for payment purposes, that the inpatient care was being furnished on the basis of the physician's judgment of the medical necessity of such inpatient care, rather than some other level of

care, as, for example, outpatient treatment. Now the feeling is strong that this provision should be eliminated or altered. We have recommended a significant modification of this provision, so that it will be requested only in long-stay cases.

Part A intermediary receipts in March totalled almost 1.2 million bills, an increase of 204,000 over February. March 1967 was the largest monthly total to date. Nevertheless, the party intermediaries still managed to clear 10,000 more bills than they received and as a result the number of pending bills dropped to 393,000.

Part A bill receipts showed an increase for every type of bill. Inpatient hospital receipts increased by 81,000, from 487,000 in February to 568,000 in March.

Extended care facility bill receipts increased from 44,000 in February to 78,000 in March, a gain of 34,000 bills.

Outpatient receipts for March totalled 446,-000, about 82,000 more than February's receipts.

Part A intermediary operations showed improvement in all performance indicators. The ratio of monthly clearances to monthly receipts rose from 98 per cent in February to 100 per cent in March.

The number of weeks' work on hand in the intermediates' offices dropped from 1.6 to 1.5 weeks' work, a new low for the program.

The proportion of bills requiring additional information from the providers of service continued to decline from 13 to 12 per cent.

The proportion of bills pending over 30 days shows a substantial improvement in March. The improvement in cases pending over 30 days is mainly due to the increase in the proportion of outpatient bills pending over 30 days — 31 per cent in February to 21 in March.

Now Part B receipts for March reached an all time high of 3.1 million bills, an increase of 400,000 bills from the month before. Our receipts in April will exceed the receipts in March.

This increase at this time of year appeared to be contrary to the experience of many major medical insurance business practices. However, it may be the result of the effect of the carry-over deductible in our program and also the filing of income taxes in the middle of April.

The increase in the number of bills cleared during the month was even higher. Over 3.4 million bills were cleared in March — 21 per cent more than the carriers cleared in February. As a result, there was a substantial drop in the number of bills pending. This month's closing pending of 2.4 million bills was 322,000 fewer than at the end of February. The number of pending bills now is down to approximately 2 million so that there was a further decrease in the number of bills on hand in carriers' offices by 400,000 during the month of April 1967.

Part B carriers also showed an improvement in all performance indicators except the per cent of bills pending over 30 days, which increased from 23 to 25 per cent in March.

Highlighting the performance of Part B carriers was a jump in the ratio of monthly clearances in relation to receipts — 104 per cent in February to 110 per cent in March. As a result of this increased productivity, the number of weeks' work on hand fell from 3.5 to 3.3 weeks. In addition, the proportion of bills requiring additional development dropped to 12 per cent. The number of bills returned to claimants or physicians dropped to a new low of 7.4.

In April we had record receipts, record processing, a record reduction in backlog, and the best performance in processing time to date.

The advent of Medicare, as with any new program, has presented some problems of adjustment. The program has been in operation

for ten months. All of our problems have not been solved. Some may never be, not all were the result of Medicare, but with experience and maturity we hope we are getting better. In July of 1966, 40 per cent of the medical insurance claims were being returned, either to the doctor or his patient, for additional information. At the end of April, and we still consider this too high, the bills returned had dropped to less than 6 per cent. During these first ten months the carriers have received 20 million bills for medical services. We cannot yet relate billings to numbers of people involved, although our estimate is that between 7 and 8 million individuals are represented in this bill total. Over 90 per cent of the bills received to date are for services rendered by physicians. Of these bills, about 60 per cent result in a payment and 40 per cent involve no payment, because the $50 calendar-year deductible was not met. This ratio should change as the program matures. Even with the last quarter carry-over provision on the deductible, we have still just had a ten-month period with two calendar-year deductibles.

Medicare is working: It is a partnership of many components; and many components are working together. This partnership can be a compatible one, since we share the same purpose — you to provide quality health care, we to pay for it under various arrangements suited to different groups which make such care available to all who need it, whatever their financial condition may be at the time they need such care. Thank you.

(Applause)

The Moderator: As you all know, we do have our Medicare operations centered in Millville, New Jersey. Mr. Park is the General Manager of that office and he's been the butt of many jokes about the chicken farmers he hired down in Millville. But the chicken farmers have produced very well, I think. I'd like to have Ev tell you a little bit about Prudential's operation in Millville.

Mr. Everett P. Park: Millville is forty minutes due west of Atlantic City. I hope that any time any of you are passing by that you do stop in and see our operations. We call this the Tri-City office because it's one part of a triangle which is formed by Bridgeton, Millville and Vineland.

We have built up a staff there, as the volume has increased, to the point where we now have 250 people who are processing the Medicare B claims. We have excellent communication facilities throughout the State with beneficiaries, all providers of service, with the Social Security offices in New Jersey, and the central offices in Baltimore.

As of the end of April we had paid 375,000 B bills for a total amount of $19,400,000. As Dr. Bell said, volume is building up and currently our claim volume is about 15,000 per week and we are making 90 per cent of the payments within two weeks; the balance are done shortly thereafter. This operation is going very well. We know we can make it do even better. This will especially come about with the continued operation of the medical community, the beneficiaries, the State and federal agencies.

The Moderator: Thank you, Ev.

The very heart of the Part B program is the determination of what benefits are to be paid for physicians' services. This is spelled out in the law and supplemented by regulations.

Now, Mr. Beatty, will you discuss for the audience how we operate the usual and customary program?

Mr. Thomas J. Beatty: Well, how did we get to the customary and prevailing approach? The first problem was one of nomenclature, since there was no published schedule. The first thing we had to look at was nomenclature. We reviewed many examples of standard nomenclature and ended up with the California relative value scale. We used this to get the "customary and prevailing" approach. Now, I emphasize it is not the units but rather, the *nomenclature* in the California rel-

ative value. Then, the American Medical Association came out with the current procedural terminology book. This is an adaptation, a condensation, in a way, of California relative value, so it is usable although it does not have the same differentiation as the CRV nomenclature.

Next thing to do was to decide what were "customary" fees for each physician as well as "prevailing" fees in localities. We began to look at Prudential major medical claims, group and individual life. I emphasize major medical because there was no effect here of a schedule. We do have scheduled plans also. We inventoried a very large number of claims and from this we secured some profiles on some physicians, on a fair proportion of the physicians. I'm not going to tell you that we had profiles on every doctor, but we did have a fair percentage. But what we *did* have and what we thought we had very reliably was prevailing fees within localities.

Perhaps the most difficult part of it was the determination of localities. When I had the opportunity to speak to physicians, this is the question that seemed to come most frequently. We took the definition as we understood it and then went to financial economists and said, "Will you tell us, using this definition, what localities are in the State?" So, they are not necessarily counties. As a matter of fact, they are not counties, they are not societies, but rather socio-economic patterns in the State. And we now have these localities pretty well pinpointed. There have been some changes because it's dangerous when you draw a line down a map and use a zip code to say this is one locality and this is another. But, generally speaking, we think it's been working well and we think we have a fairly good idea of what a locality should constitute; and it must constitute a socio-economic mix.

Mr. George T. Garver: I was just reading over the latest AMA News of April 24th and saw an article that indicates "SSA explains use of form by M.D.'s". The first paragraph reads: "The Social Security Administration calls attention to the fact that the Form 1490 is designed to be used by physicians whether or not they take Medicare assignments."

This summarizes the fact that we have been getting in the assignments but also in many instances getting in the itemized bills which are attached to the 1490 Form. In many instances particularly with the office assistant who is helping the patient to fill out the first part, it would be worthwhile to continue on and complete Part 2. And if the doctor does not wish to accept an assignment, this can be indicated, under Section 12. In this way, rather than having the patient submit itemized bills attached to the form with just Part 1 filled out, the entire form then can be sent in and you run into less of a chance of having the itemized bill separated. We would encourage, where this can be done, that this idea be followed. It will assist our people in the claims processing division. You have received these forms and also envelopes. They are pre-printed. You also have a form for ordering them; or you can call our Millville office. We want to keep you supplied with them so there is no problem on that score.

We hope you understand the advantages to the carrier in receiving the form completely filled out in preference to the itemized bill, because we do have the problem of the itemized bill often getting separated; when that happens, we have to get in touch with the beneficiary or with the physician.

Mr. Park: Everybody knows there is a $50 deductible in each calendar year under Part B coverage. Each individual must meet this before benefits are payable. There is also a "carry-over" and many people do not have an understanding of what this means.

Simply, it means that for any part of the deductible in a given year which is satisfied in the last three months of the year, that part can be used also to help satisfy the deductible for the next calendar year. For instance, if a bill was incurred for $30 and used in November 1966 to satisfy part of the deductible, it would also be used to satisfy $30 of the deductible in 1967.

Sometimes a question is asked: In what order do we apply the bills to the deductible? Well,

in the interest of service and expediting things, we process the bills as they are received. The first one in is the first one that gets applied to the deductible, the second and, third follow thereafter.

Mr. Beatty: We are using the relative value nomenclature. We don't need a great deal of information. Consider the symbols "O.V." There is a great difference between a routine office visit by one of your patients and an initial office visit where you would be doing a diagnostic work-up and a history. So, I would emphasize that while the condensations and the symbols are perhaps easiest, I think if your medical assistant would just indicate this is an initial office visit, or this is a house visit that I went on at twelve o'clock at night, as opposed to a house visit during the day—this is the kind of differentiation that would be most helpful to us and, in the long run, to you, and your medical assistant.

The Moderator: Tom, what about other items that might appear on the physician's visit in addition to his service?

Mr. Beatty: If there was an additional charge for an injection, this is the kind of thing that we need to know.

The Moderator: Recently you have received some letters from the Prudential about independent laboratories and their certification.

Mr. Park: When the Medicare program started, it was necessary to operate under an interim procedure for services rendered by independent laboratories. Meanwhile, the State Department of Health and the Department of Health, Education, and Welfare completed a survey of all laboratories and determined those meeting the program's requirements.

On April 21, we sent a letter to all doctors notifying them that after May 15th the interim program would cease, and pointing out that they could check out certification with the laboratories that they normally dealt with and make a decision on whether they wanted to continue the relationship depending upon the certifications.

The week of May 1 we sent out a second letter with a list of all laboratories approved and the specialties which had been approved for them. Additional laboratories and specialties will be approved as we move along in the program. In this letter we pointed out that Medicare reimbursement would be made only for these approved independent laboratories. And, perhaps it was because of the wording, we did notice a few doctors thought that they could not be reimbursed for laboratory work done in their own office for their own patients. This is not so. Doctors can continue to bill Medicare for this work and will be compensated for it.

The Moderator: A problem we had initially in the Medicare program was how to handle the claim if the beneficiary died. We did handle it in one fashion in the beginning. Later on a procedure was adopted by the Social Security Administration to be used by all carriers.

Mr. Garver: In the early days, before this was clarified, we used to send out a small estates notice and we had quite a few repercussions from this. We were trying to resolve the problem and no one had the answer. But finally SSA did come up with a ruling about a patient who has died. In filling out your 1040, all that is necessary now is to indicate on Section 5, under Part 1 where the signature of the patient would normally be, that the patient is deceased, and if you have it, the date. If the doctor accepts an assignment in this instance the form can be sent in and payment can be made to the physician.

If the assignment was not accepted and a relative pays the bill, then they file that with us and get a Form 1660. This can then be taken care of so that payment can go to a relative or a member of the family. But this did help to resolve a problem which was a burning issue up to the point that we received this information, and this has been going quite smoothly ever since.

The Moderator: Another problem we have run into is an understanding about the payment for rental of durable equipment. Tom, would you like to talk about this point?

Mr. Beatty: As with everything, the doctor indicates medical necessity to us and the criteria that we have been using is that if the item has any usefulness to the patient in the absence of an illness or injury, we might have some reason to call you; for example, a Slender-Cycle or something of that type.

The other thing on durable equipment that has come up repeatedly is: Why can't we purchase it — a cane or a crutch or something like that? Well, the legislation clearly says that it *must* be rented. But there is now the ability for a lease-purchase arrangement so that after the cost price of the item is amortized your patient can, in fact, own it and this would be between the supplier and your patient. Sometimes you indicate a wheel chair-standard or motorized. If we see a motorized version, we may occasionally call you and say: Doctor, was this in fact what you intended the patient to have?

The Moderator: Another benefit under Part B which is sometimes misunderstood, is the subject of ambulance services. George.

Mr. Garver: Ambulance services are a part B benefit, though the ambulances, in some instances, are owned and run by a hospital, or an extended care facility, or a home health agency. If this is the case, this is paid for on a "reasonable cost" basis. Otherwise, if it is an independent ambulance service it's paid on a "reasonable charge" basis.

At the present time, 21 ambulance services in this State are certified. Three factors are involved here, three conditions that have to be satisfied before payment can be made under the program for the ambulance service.

First it has to be a *certified* ambulance service through the carrier. We do make a point, and are continuing to do this, to go out and inspect the ambulance services to see that they fulfill the requirements.

The *second* factor is, whether the use of any other method of transportation, such as an automobile, a bus, a station wagon, or a plane, regardless of availability, is medically contraindicated by the individual's condition. In other words, the medical situation should be such that an ambulance is necessary. If they can use any other type or method of transportation, even thought it may not be available, or they cannot pay for it, if the medical condition is such that it is contraindicated that an ambulance not be used, then of course it will not be paid for.

The third factor is the requirement that a patient be transported to the nearest hospital with appropriate facilities, or to the one in the same locality as that hospital. And what we use here is the geographic territory surrounding the institution from which individuals normally come—are expected to come—for medical services. So there could be an instance, for example, of a patient in South Jersey who might have to have open heart surgery and the only place he can get this would be at Jefferson Hospital in Philadelphia. Then it would be necessary for him to have ambulance service. And, under these conditions, because of the medical necessity and the fact that there was not a properly equipped hospital in that particular locality, it could be taken care of for this patient to go to Philadelphia.

However, there are other instances where a patient might have a mental condition. Perhaps there would be a mental hospital 200 miles away, while within their community there was a psychiatric section of a general hospital that could take this patient. In a case like this, the ambulance service would be taken care of only within that locality to that particular institution.

The patients do need something when they are using the independent ambulance, a notification from you on a prescription blank that there is a necessity for this use of this particular ambulance. If it is handled through the ECS or through the hospital, this is done through a normal certification.

The Moderator: Recently Prudential mailed to every physician in the State a letter and sample pamphlets which might be of some help to you and your office assistant. Tom, would you comment on that, please?

Mr. Beatty: These pamphlets were mailed to you doctors. They give the individual a pouch. I think of my mother and father — they take the bills and just put them in a corner. And actually the idea was that they could have some spot to save the bills and make a record of them; and also, perhaps more valuable, are pamphlets in here explaining the intricacies of Medicare, the home health plan, medical insurance, and the calendar deductible — some of the more misunderstood aspects of Medicare.

Mr. Garver: We did mail out, to all physicians, two sets along with a card. This card could be sent back to us and we would relay it to the local office near Millville so that a supply could be sent to the physician as he needed it for use in his office.

The Moderator: These pamphlets are free. They will be of some help to you and your office assistants when the patient asks questions. There is a considerable amount of information available in this series of pamphlets. It will save you some time, rather than take time to answer these questions or for your girl to answer them, to hand them some of these pamphlets. The family could keep them for reference in the future.

Another phase of our operations which Dr. Bell touched on is our involvement with welfare. I'd like to ask Dr. Bernstein to explain to you the arrangements that have been made with the Prudential on this subject.

Dr. Bertram M. Bernstein: The public assistance population in New Jersey accounts for less than three per cent of the total population. For Medicare, we are talking about three-tenths of one per cent of the State's population. To phase in this group with the other "over 65" individuals in our State and also to abide by the coming changes in philosophy of the welfare administration, both nationally and locally, and in the State, to do away with the idea of "charity medicine" or "welfare medicine," we thought of an arrangement within our fiscal capabilities whereby physicians would not have to deal differently with the 65 years of age and older client receiving welfare assistance, or patient receiving welfare from his other "over 65" people. For that reason we discussed first the concept of having Prudential function for us as a fiscal agent. Then we approached the Medical Society, and worked out an arrangement with the Medical Society, which hasn't met with a hundred per cent approval of physicians. The important thing is it's a step in the right direction. And through this doctors do *not* have to contact the welfare boards for permission and so on. They can deal with the welfare patient over 65 in the same manner as they do with their other patients over 65. This has worked out well for us. It should have worked out well for physicians in that in effect, if they use the form 1490, it cuts down their paper work, their telephone calls, and the needless red tape with the welfare program.

The Moderator: We have had some problems in the processing of welfare claims. I'd like to have Ev Park discuss where we stand on welfare claims.

Mr. Park: Most of these have gone through very smoothly. Actually, they are processed first through the Medicare system to see what is to be paid out of federal funds and if a check is to be issued, it is generated, then it is passed on through the welfare system. Whatever is payable from that is paid out. To date some $196,000 in welfare funds have been paid out, involving some 16,600 bills. With a small ratio of these cases, there was some question about Part B eligibility and getting all the records straight between the County, the State, and Social Security in Baltimore.

While this has been going on for some time it's on its way to a resolution. We last week sent out a letter over Dr. Engelman's signature to those doctors who had pending claims

and attached a list of the claims. Some of these are already on their way to being resolved. There are some 950 claims that should be resolved within the course of a few weeks. From that point on we would expect that there would be a minimal problem in this area.

Question From The Floor: If the welfare patient is 65 years or over, does he have to accumulate $50 in receipts or does he have to have that done in the welfare board? How is the computation made to the welfare patient?

Mr. Beatty: You do take an assignment on a welfare case. So the contract that was negotiated between the Medical Society and the State guaranteed the physician 80 per cent of charges. So for that first claim that comes in that normally would be credited to the deductible you should get a no-payment statement from the federal funds, followed by 80 per cent of your charges in a welfare check.

The Moderator: Still handled separately. They would not be paid in a single check, but you would receive payment of 80 per cent of the $50 deductible from Welfare funds, issued to you separate from the Medicare payment, if the bill was over $50.

Dr. Bernstein: It's Welfare funds but the Prudential handles it. They have like two accounts; one is Social Security and one is Welfare.

Mr. Beatty: Shortly, we hope that when the "no-payment" letter goes out saying that nothing is payable on federal funds, simultaneously with it, the Welfare check will go. But this takes some rather fancy computer programming and so that hence you see the "no-payment" letter, if you will wait a day or two, the check should be there.

Dr. Gardner: We are having a little problem in Essex County with the ambulance service because the private ambulance companies do not want to take 80 per cent as payment in full. Has there been any provision made as to any arrangement under discussion as to how this 20 per cent will be handled?

Dr. Bernstein: Well, this is not a Prudential problem; this is a Welfare problem and this is being worked out now. We realize this is a hole in our present program and this 20 per cent will be paid.

Dr. Gardner: Ambulance companies are refusing to take patients to hospitals under certain circumstances. I thought it might be well to see what other counties are doing and how they are handling the problem.

Dr. Grimes: What is Medicare costing in this first year of operation? And what is the percentage of occupancy of hospitals by Medicare patients?

Dr. Bell: Well, the figures that we have to date on the Medicare program, in both Part A and Part B, indicate that expenditures are at the level that the actuary estimated. With the Weigand bill in, with the Weigand processing there is some question, but that's the information that we have at this time.

There has been a marked increase in hospital costs in the past year and these, on a short-term basis, can affect the short-term estimate of the actuary. But the actuary in doing the Medicare financing—has done it on short-term, intermediate, long-term, on low cost, medium cost, high cost estimates and he worked it all out—and says he is within his "ball park."

So far as the occupancy of hospitals, I do not know what that figure is.

Dr. Madara: I can answer Dr. Grimes as far as occupancy. In Salem Hospital, which is a small hospital of 150 beds, we ran statistics for three months, comparing October, November and December of 1966 with October, November and December of 1965. There were 25 per cent more patients over 65 in 1966 than in 1965.

I'd like to ask one question. What percentage of people in New Jersey over 65 have *not* signed up in Plan B?

Mr. Park: The best figure I have heard is seven per cent.

The Moderator: In other words, 93 per cent of the people signed up for Part B.

Mr. Park: These people have an opportunity to enroll again this fall.

Dr. Eckstein: Do beneficiaries under the Railroad Retirement Act fall under a different category?

Dr. Bell: Only that a different carrier processes the bills — the Travelers Insurance Company.

Dr. Eckstein: Now, included in the law is the statement about the "usual and reasonable fee," the usual and "customary" fee. Travelers has its own schedule of fees for 65 and over under the Railroad Retirement Act.

Dr. Bell: The Travelers Insurance Company operates under the same guidelines for the determination of "usual, customary and reasonable" charge as does any other carrier. The delegation to the Travelers Insurance Company to act as carrier for the Railroad Retirement annuitants does not result in any different fee schedule guidelines being issued by SSA.

I'm interested in the statistic that the 1966 vis-a-vis the 1967 occupancy rate of a hospital was 25 per cent more, and I would be interested in the reaction. Since the doctor certifies as to the necessity for hospitalization, I assume that this merely means that there is increased need for hospitalization.

Dr. Madara: There are people being admitted who were not admitted the year before.

Dr. Bell: There are people being admitted who would not be admitted the year before, and I guess this is my question as to what your ideas would be why this would be necessary, since our regulations provide that the doctor must certify as to the medical necessity for this admission. So I assume that the admission is medically necessary.

Dr. Irwin Smith: These admissions had been necessary for many years; however, unfortunately a lot of these people have a strong feeling about their obligations to pay hospital costs and doctors' bills. The older they are the less security, and they have even a stronger feeling. Some of them are dependent upon their families. Again, realistically, their families don't assume these obligations frequently. So these combinations of factors have created a lack of proper medical attention to the older age group and this insurance program has given them the opportunity. They have therefore asked for more and there's been a greater acceptance to going into a hospital.

Question: I'd like to use Form 1490. But I find if I have a patient in a hospital two or three weeks, then he comes out and I see him in the office a half dozen times and include a blood count, it's very difficult to fit all that information on the Part B part of 1490, so I just run it out on my bill, which is blank, and I can use any form I want, and it works out very well, and I staple it on. Maybe you should give us some illustrations. What's a good way to do it on your form with all the lines and the very narrow space for the date and a big space for nature of illness. It may be the fault of the form. I'd much prefer it blanked out and it's working.

Mr. Beatty: I have seen these come in with each date shown and this is not necessary. You can span dates. Thus, you can show March 10th through March 15th, daily care.

The Questioner: Six office visits in several months or something like that?

Mr. Beatty: Expand dates of continuous — for example, in a hospital where you saw an individual every day.

The Questioner: That's easy. What about six, eight or ten office visits, sometimes you give a shot, sometimes you don't, maybe one of them is for a blood count. It gets pretty cumbersome.

Mr. Beatty: Not in the same sequence. For example, once a week or once a month or something like that, Doctor, we would need the date, the actual date.

The Questioner: Unless you send a bill in every week or every month or something like that. That's too cumbersome. Let it run for six months and you will never fit it on those forms.

Dr. Bell: I think the thing on behalf of the carrier we would plead with you for is that if you do use this device, Doctor — and you must be the one to decide — if we are really going to make the concept of "usual and customary" fee work, then the physicians must give the carrier enough information with which to make a decision as to what is the customary, the usual charge, for this service. I have seen the physicians' receipt where the girl has written out five office visits, whatever the sum of money was, and a signature. Well, it may or may not have been the "usual." One of them may have been an unusual visit. One of them may have been a regular visit. If you are giving the detail with which the carrier can make the "usual and customary," this is the burden of our message.

The Questioner: There's a large amount of paper needed and it won't fit on the section he provides us, yet at the same time he says we must use it.

The Moderator: Of course, you could use more than one form and staple them together.

Dr. Lloyd: I'd like to ask Mr. Beatty how many socio-economic areas did he finally end up with in the New Jersey.

Mr. Beatty: About a dozen.

Dr. Lloyd: I am surprised. Pennsylvania Blue Shield worked out for the whole Commonwealth of Pennsylvania, which is a much wider geographical and economic group, about the same number. They are going into "usual and customary fees" and they have come up with, you say, a dozen in a state the small size of New Jersey with rather homogeneous areas in various parts.

Mr. Beatty: Well, there are many factors above. Socio-economic was one that I mentioned, Doctor, but there are others. We are having population changes and shifts in New Jersey. A medical center connected with an area has a great influence. This is difficult and we have had an economist take a look at it and this was his best judgment of socio-economic areas in this State as of now.

The Moderator: One thing you have to consider, too, Doctor, is the fact that you have to try and get a nice blend here, a composite. You can get too many or not have enough. If you don't have enough, you may average too many things out. This would prevent you from recognizing some of the usual customary fees. So you have to make this arbitrary decision whether you are going to have twenty or you are going to have two. And we are continually looking at this and examining it all the time to see if it really reflects the charging practices around the State.

Dr. Bedrick: Has there been any study of over-utilization? You hear that the doctor over-utilizes because he charges for daily visits. Has there been any check on this; in case some senator asks can we be given a clean bill of health?

Dr. Bell: The Social Security Administration activity with the carriers has largely been in the area of the development of guidelines for the determination of "usual and customary," the reasonable charge. And very frankly our approach has been that the Congress said: Establish this program on a "usual and customary" charge. The physician is to be compensated his "usual and customary" charge, not a fixed fee schedule. And the development of the necessary physician profiles to put into effect the intent of Congress has really occupied most of our time. Now we are in meetings with the American Medical Association in talking with them about mechanisms effectively to measure utilization and exercise utilization safeguards.

One of the carriers on the West Coast has an elaborate system showing utilization patterns. Others do not. It varies from one carrier to another to the degree of EDP sophistication as to what information it does have. We know of no indication to date of any unusual utilization patterns on the part of physicians in the Medicare program.

Dr. Chamberlin: This brings me right back to my question I wanted to ask. When and how is HEW going to start policing utilization committees?

Dr. Bell: The matter of utilization safeguards is a contractual one between HEW and the carrier. We look to the carrier to carry out its contractual commitment with the Secretary.

Dr. Chamberlin: Then I am to infer from this that this will be something to be done by the carrier and not directly by HEW.

Dr. Bell: That is correct. Well, the other issue on utilization review involves state health departments.

The Moderator: I want to clear up one word. Tom Bell mentioned "carrier." Actually it's the *intermediary,* the Part A intermediary, that has this responsibility. Prudential is involved in Part A, too. So we will be involved in this kind of thing for those hospitals and institutions we serve. But it's actually a dual approach. The contract HEW has with the department of health in a state for the initial certification and continuing review, or the capabilities of providing, also provides that the department of health will have this responsibility that the utilization committee plan and function, which originally was ascribed to the department of health, is actually operating the way it was to do.

The intermediary in his contract has a provision to assist the institutions in the effective operation and utilization of review committees. So there is a dual approach to this — the intermediary to the department of health. Social Security and the intermediary are still working, and the departments of health, too, as to how to make this function. Intermediaries do have an on-going relationship with the institutions and the departments of health. In some way, we have to blend department of health and intermediary operation together under some guidelines which we don't have yet.

Question. In my area we have volunteer ambulance squads. Can anything be done to reimburse these squads for transporting patients?

Dr. Bell: There is no provision in our policy for the reimbursement to a provider who does not charge.

Mr. Beatty: Most volunteer ambulance charters in fact have a prohibition against charging.

The Moderator: That's true in New Jersey.

Dr. Grimes: I'd like to know what the view of the HEW is to the expansion of outpatient coverage. Appropos of my original question about the percentage of hospital occupancy, I am thoroughly convinced that there is unnecessary hospitalization of Medicare patients. In fact, going over a list of 26 people, on a utilization committee list two weeks ago, it was my feeling that 14 of these 26 patients were unnecessarily hospitalized. My evaluation of this situation is a little bit higher than that of most on the utilization committee. I'm sure some of the people feel that my father was a bachelor. But these are individuals who were anemic, cause undetermined, and could very well have been worked up in the outpatient clinic. Or they had gastro-inestinal x-ray series and barium enemas, and they are being held in unnecessarily long. It has to be our job to put teeth in this. But what I'm not going to — I say I as the average physician, I'm going to be careful that I don't step on my colleagues' toes, but this is going to be a form of abuse, and I know it is a form of abuse from the fact that I have six cancer patients whom I cannot get into a certain hospital right now because the admission situation is

locked. I'm sure that the rest of the surgeons in this room here will find that they have many similar complaints. They probably don't want to air it here, but this is the fact and the doctor is going to be an unnecessary abuser of this.

What is going to be the answer? Either we're going to have to put some teeth in this or we are going to have to get expanded outpatient care facilities. Mind you, these people need care and the doctor so certified them on initial entrance. I can't quarrel with him if he's got a patient who is fainting from anemia. But this patient really could be handled as an outpatient without keeping him 20 to 30 days in the hospital. And you find that sometimes as these hospitals get crowded, this patient is 14 to 16 days on medical service before surgical consultation is set. These are where the snags are building up in the population whom the doctor cited in the Salem Hospital. These are popping up in other hospitals that I am familiar with, and I am getting a little concerned.

Dr. Bell: Well, let me tell you. You ask what HEW's position is. I don't pretend to be able to say this is HEW's position on this point, Doctor, but let me answer it in this way. The Congress said here are a number of services which you can pay for or will pay for — doctors' services, physicians' services and other kinds of medical suppliers. You can then provide hospital care; you can then provide extended care facilities; you can then provide home health agencies, and I think this is a proper reflection when I say that I'm sure through the next years we must attempt to develop all of these resources so that there is the right number available for individuals who need the service. But the decision as to where the individual goes to get this care must, in my opinion, rest with the practicing physician. We have to develop the resources. There has to be home health agency service; there have to be extended care facilities; there has to be a hospital; we have to be able to reimburse physicians; but as to where you go, where you send the patient to get the care, I think this has to remain with you and I think that's where you would want it to be.

A Voice: I see that we have the press here and I thought this was supposed to be a meeting in which we could freely express our opinions. Now, it's been my experience that the press has always given rather an unfavorable picture of the medical profession, so I'm just throwing this out as a comment.

Dr. Madara: Our length of stay between 1965 and 1966 actually increased totally in the hospital by nine-tenths of a day. It was not reflected by the people over 65. Actually they were the same or a little less. The length of stay was due to increased length of stay of those under 65.

Dr. Eckstein: In the use of outpatient facilities it's necessary for the physician to certify to the need of those facilities. In our experience in the hospital, we run into the rather cumbersome problem of referring a patient, let's say, for an X-ray, writing a note in the office and find that we must sign a certification in the outpatient department and are told that in order for the hospital to be reimbursed they must be able to show this certification. But the certifications are piling up in the hospital. Now, who is interested in them and where are they going to go?

A Voice: I was very interested in Dr. Bell's presentation at the very beginning and I think that we should put it into our JOURNAL I'm sure it would alleviate a lot of these questions. He stated that it would take years for this Medicare program finally to reach a destination of some sort of another. I think it will answer a lot of questions that were asked. If he doesn't have the answer for it, no one else does either.

The Moderator: It's getting late and I think we ought to draw the meeting to a close. If anyone wants to speak to us separately, we'll stay for a while and talk to you.

(Applause)

(The meeting was concluded at 4:40 p.m.)

MEDICAL-SURGICAL PLAN

Saturday, May 13, 1967, 5:00 p.m.

Nicholas F. Alfano, M.D., President of Medical-Surgical Plan of New Jersey, presided.

President Jehl: I'm going to ask Dr. Nicholas Alfano, President of the Medical-Surgical Plan, to come to the podium and to conduct this meeting. Dr. Alfano.

Dr. Nicholas F. Alfano: Thank you, Dr. Jehl. As was indicated in the report to the House we do not propose, this afternoon to present a formal paper. We felt that the best manner by which to conduct the meeting is to throw it open to the members, to try to satisfy the questions that may come directly from the floor, rather than using up time by a formal presentation from myself. We have a number of trustees present who, I'm sure, would be happy to contribute to any discussion that might affect the trustees. Also, we have a number of our staff here who can answer some of the questions if so required.

Dr. Anthony L. Spirito (Union County): Many of the Medicare patients now bugging us say that they have Blue Cross/Blue Shield supplemental coverage. They are paying out these office visits and any x-rays or anything else amounting to maybe $30 or $40. They are paying a supplemental fee as charged by Blue Cross/Blue Shield, the Prudential, or other insurance companies. They want to know how to get their money back, this first $30 or $50 for which they are paying in premiums. In my experience, all the plans wait until Medicare processes the claim before anything can happen. Now, how does the patient get this processed?

Dr. Alfano: The complementary coverage that we provide is of two types. The *Blue Cross-Blue Shield 65 Program* limits its benefits to in-hospital services only. There are no office services covered under that program. In the *Carve-out Program,* however, which is the other complementary program, it depends upon what was previously covered under Blue Shield before Medicare came into effect. This *Carve-out Program* may cover not only the in-hospital services but also out-of-hospital services. For example, if a group had Rider J for its members, then out-of-hospital services as provided in Rider J would be covered in that type of program. You asked when Blue Shield could make payments in these cases. This does require an explanation of benefits from the carrier as to the amount of payment that has been made by them in order for us to determine the amount eligible for Blue Shield payment under either of the two complementary types of coverage.

Dr. Francis C. Weber (Essex): Does this mean that the individual who has Medicare must first pay $50 before he gets benefits from Blue Shield?

Dr. Alfano: No, in the explanation of benefits that we do receive, we see that the carrier under Medicare has, in a number of instances, deducted from the reasonable charge or the reasonable payment that would be made in a particular case, has deducted the $50 deductible if it had not been previously satisfied. When that is indicated and the Blue Shield claim comes into play for the complementary coverage we would pick up the payment for the deductible, the $50 or any part of it that had not yet been satisfied. Do I make myself clear on that?

Dr. Weber: No, sir, you do not. Must the $50 be paid first before Blue Shield pays anything? I am talking about a patient who is over 65, who has both Blue Shield and Medicare. A claim was sent to Blue Shield for, specifically, an electrocardiogram, for which you pay $15. The patient then received a notice that they will process that *after* they get some clarification from Medicare. Now, where does this patient stand?

Dr. Alfano: Well, the clarification that we

required was the explanation of benefits because we had no information as to whether the $50 had been satisfied.

Dr. Weber: Well, then that's the answer. They must satisfy the $50 before you consider their claim. Is that right?

Dr. Alfano: The patient *need* not, no, but the carrier would indicate that on its explanation of benefits. Let us assume a service was rendered which the carrier determined to be reasonably paid at $100. This patient, however, had not previously satisfied the $50 deductible.

Dr. Weber: That's the question. He must satisfy the $50 first.

Dr. Alfano: Right. The carrier would satisfy the $50. It would deduct the $50 from the 80% of that $100 it would have paid. So that in this instance the $80 would be reduced to a $30 payment by the carrier because it deducted the $50 which the patient had not previously satisfied — the beneficiary had not previously satisfied. Is that clear?

Dr. Philip R. Ambola (Essex): Don't you have a plan that pays the first $50?

Dr. Alfano: Yes, we do. In our complementary coverage we cover the $50 deductible but we must know from the carrier as to whether the $50 deductible has been covered in part or in whole.

Dr. D'Ambola: And also don't you have a plan that takes care of the 20 per cent that Medicare does not?

Dr. Alfano: That's right. We pay the 20 per cent that the beneficiary would ordinarily be liable for without our complementary coverage.

Dr. Joseph M. Gannon (Union): Recently a patient's family insisted that I send back to them the Blue Shield form, Medical-Surgical form, after I had completed this. Rather than get in a rhubarb, I did it. Is this agreeable to you for a Medicare patient?

Dr. Alfano: No, it is not commonly done because there might be reluctance to do so by a doctor depending upon the type of diagnosis that would be reported. There might be something that the doctor would not wish the patient to know.

Dr. Gannon: You have no objection to it. This is the question.

Dr. Alfano: No.

Dr. Albert F. Moriconi (Mercer): Can we change the subject to something else that's supposed to be discussed today — this business of the survey?

Dr. Alfano: That has been referred to Reference Committee C and I would prefer that all discussions on the supplementary report which has been referred to Reference Committee C, be withheld until the meeting tomorrow.

Dr. Moriconi: I thought that was one of the things to be talked of today, right here. After all, most of the Board of Trustees are here now; they can hear it. At Reference Committee C most of them won't be there.

Dr. Alfano: The trustees are here. The practice has been, though, that if a subject was presented here at the open discussion and that subject was to be considered by Reference Committee C, then we ask that any discussion be withheld so that the committee members would have the benefit of any discussion that might take place concerning the particular matter that they had to report on. And I don't know whether the Reference Committee members are here. It might not be fair to discuss this without having the committee members have the benefit of what may be discussed here and I would urge that anyone who has anything to say at all about the supplementary report on prevailing fees make every attempt to be at Reference Committee C tomorrow or have some one in his behalf present what you would present here.

Dr. Elbert T. Pogue (Union): In the case of

Blue Shield contract, I believe the proper procedure is to submit the report in this case to Prudential and then after they have made their payment and submitted the report, that the receipt be sent, along with the Blue Shield form, to Blue Shield. I am told that what Blue Shield wants is the yellow copy that is sent to the patient. Will Blue Shield accept the copy that goes to the physician? It is sometimes difficult to get these from patients.

Dr. Alfano: We accept either one.

Dr. Pogue: I mean will you accept the physician's copy?

Dr. Alfano: Yes. Yes, we do.

Dr. Moriconi: This is supposed to be an open meeting on the Blue Shield Plan. It is much better to discuss this here than on Tuesday because that certainly would prolong the meeting. Something should be done about certain things now—rather than wait until later—when everybody that needs anything in the plan is sitting here and can hear what other people are thinking about this plan, not by secondhand.

I thought, for sure, that this was going to be up here for open discussion today because there are many features about this new survey, the new idea on the Blue Shield Plan, that should be aired thoroughly here rather than any place else.

Dr. Alfano: The Reference Committee hearings are tomorrow morning. I don't know whether I can agree to have the matter discussed at this time. What action could we take even though it were discussed? The Reference Committe will make the determination as to what it will refer to the Board or to the House of Delegates.

Dr. Moriconi: May I ask our parliamentarian whether we have a right to discuss this thing here today or not?

Mr. Backes: You can discuss anything you want to here. The chairman should be entitled to control within time and reasonable rules. It does seem that if there are other items for discussion that should come up preferentially, they should be discussed first. But if time allows, Dr. Moriconi might be heard.

A Voice: The Chairman of the Reference Committee Dr. Pogue, is here. His preference should be respected.

Dr. Alfano: I have indicated what the usual procedure is concerning a matter that is to be considered by a reference committee. Now, apparently there are some objections to that. Perhaps Dr. Lloyd can contribute something.

Dr. Samuel J. Lloyd (Mercer): Dr. Alfano, this is a matter of considerable concern to a great number of people, all the practicing physicians in the State. I don't think we should ask Dr. Pogue to make a commitment for his committee. I think what he hears tonight, he will hear tonight. What he hears on Sunday, he will hear on Sunday. I think if Dr. Moriconi is going to be obliged to be, as others of us are going to be obliged to be, elsewhere tomorrow—I don't know whether Dr. Moriconi is actually free to come before Reference Committee C tomorrow to make any statement. He has many interests and other committees may require his attention first.

I think we could hear what Dr. Moriconi has to say. If you feel it doesn't warrant a comment from you, I think you can make that statement at the conclusion of his statement. But I do think he is entitled to the floor.

We have made a great to-do about getting people to come to this meeting and here is a man who has come, he is prepared to make a comment, and I think we ought to hear what he has to say.

Dr. Alfano: I have no objection to Dr. Moriconi making any statement he wishes.

Dr. Pogue: Since the question has been raised,

as Chairman of Reference Committee C, I have no objection to any discussion that takes place here. I came to stay for the duration of this meeting and will make notes of what discussion should occur here and will take it to the Reference Committee tomorrow morning.

Dr. Alfano: Dr. Moriconi.

Dr. Moriconi: This is in reference to that survey; we all received two letters on it in the past few months and there are many phases of this that have not been explained. I just want to make sure that certain things were taken into consideration. In 1942, we put in the Blue Shield Plan, Medical-Surgical Plan of New Jersey, with the specific purpose of taking care of people with catastrophic illness. The idea was to help the people of low income pay their medical bills without causing them to go broke. That was the basic principle of all this, and it was a move on our part to stem the wave of socialized medicine. It was a very laudable enterprise. Most of those who signed up for it at that time felt that they were doing a service to the community, to the State, and to the people of the State.

Now, over a period of twenty-five years things have changed considerably. We have gone up from a required minimum of, let's say, $3000 up to $7500. Recently we had this auto policy situation where they go up to $7500 an individual, and no income other than that was to be counted except the base pay the patient gets.

This is a tremendous change in the philosopy of Blue Shield. Are we still in the same business that we were before? Are we here to try to help the people who can't pay their bills properly without a tremendous strain on their pocketbooks? Are we now a commercial insurance company in competition with other insurance companies? This has never actually been decided by our Society. I don't think that I have missed a meeting here in twenty-two years, since I got out of the Army, and I don't believe that at any time have we ever discussed changing the theory or the thinking behind the original Blue Shield idea.

This is a tremendous change and I just wanted to be sure the Board of Trustees of the Medical-Surgical Plan realize that this is a considerable shift in purpose and in philosophy. I don't know that they gave that a great deal of thought. They may have but they surely didn't decide in favor of the poor man this time. They actually decided on keeping this particular group in business on almost a commercial basis, utilizing the fees that they pay the doctors to compete against the others. I won't say that our fees are too low; they have gone up a bit. But under the circumstances we should have some other thing to think about.

Number 1 — we have for years been battling people for third-party situations where a man goes into a hospital from an accident and he is assigned to a surgeon and if he happens to be a Blue Shield participating doctor that takes care of him. No bill can be sent for the additional work above the cost. Is this new survey contemplating making the change that will permit a choice from the standpoint of the physician?

Number 2 — Has the possibility been thought of setting up an indemnity plan? The Mercer County Medical Society, many years ago, came down to the Society here, to the House of Delegates, and said we should go on an indemnity plan because we felt that would be the easiest way and probably the best way to sell this project. Is this new survey going to be placed on an indemnity basis? Are we still going to be participating doctors in which we can't charge any more than we have been told we can charge or we accepted from the beginning?

Number 3 — are there any safeguards against changes in fees? I mean by that once a man participates and he decides to accept a certain fee, is he going to have anything to do about the new fee or a change in fee? Who is going to set up the fees again — a group that's up there in Newark that doesn't represent any particular grouping anywhere? Is it going to be direct representation from each county, from certain groups of people, or certain so-

cieties? Is there any consideration going to be given to the specialists?

In New York City they have a plan that takes care of situations like that where they pay the specialist a little bit more and the people are entitled to the use of the specialist in their services. Has that been taken into consideration?

These are things that should be thought of by the Board of Trustees, before deciding on anything in the future for our society. Are we now becoming competitors against commercial insurance companies of New Jersey? And if the survey means that we are going to sign up on a participating basis for an insurance company of a nature which is far away from the orginal philosophy, serious thought should be given to the idea that many doctors may not want that as the proper thing for us to go into. We don't want to be considered to be commercialized physicians utilizing our positions to sell insurance, underselling other insurance companies. No insurance company has ever come to see me about this before nor will they afterward, but I'm just saying I think we should not be commercially motivated insurance company people.

Dr. Alfano: Every major change, including the change in the income limits, has been sent to the Medical Society before the Plan actually put it into effect. The latest one which you referred to was the "auto contract," the contract which increased the income limit provision to apply to that of the employee alone rather than to the joint income. Concurrently with that, the Board had proposed a 15 per cent increase in fees across-the-board. That was sent as a supplementary report to the House of Delegates at the 1966 session. It was referred to the reference committee and the reference committee recommendation was to approve that particular part of the report and the House of Delegates concurred in the reference committee recommendation and *did* approve the auto contract.

Insofar as the prevailing fee program is concerned, we are only doing what the trend of times compels us to do. We are not responsible for the inflationary trends today. Medicare has played a prime role in our change in philosophy. Not too far from now when our Legislature adopts a Medicaid program, they will be practically eliminating the indigent, for whom this plan originally was formed, or at least it was for lower income individuals. Now those people are going to be given medical care by the government and paid for by the government. And so that what we are thinking of in our programs in the future are the working, earning population under 65 and we've got to develop programs that they want. They are dictating what they want today through union-management negotiations. There is an increasing trend toward expansion of the fringe benefits. More and more benefits are being negotiated for and being won in these management and labor negotiations. We ought to stay in business; indeed the very fact that you are here expressing your views should indicate to you the difference between us and an insurance company or an indemnity company. You don't get this opportunity anywhere else. And your statements are certainly taken into consideration by the Plan. Changes are made in accordance with many of the recommendations brought to us, either through medical society groups, individual doctors, or in any other manner. But the doctor has a voice in Blue Shield and I think we shouldn't give up this arm that the Medical Society has.

Dr. Smith (Burlington County): Yes, we do have a voice. However, in the years that we have had this plan in effect every comparison to the commercial plans shows that our payments have always been less. This is a problem and it always has been. You must have noticed that more and more doctors are not participating because of this. Problems have been created with patients who are *not* covered by the plan because their income brackets are too high. All of these on-going problems are not being met by the Medical-Surgical Plan as well as they might have if they were in true competition with the commercial plan. To go on as a "business," you must upgrade your schedules, because more and more of the doctors will not otherwise participate.

Is there still the need for the Medical-Surgical Plan, with the demands of labor, management and government creating other types of insurance programs sponsored by commercial carriers and government itself? Why do we need the Medical-Surgical Plan if it has not been able to stay right up on the top level with the rest of the good commercial plans?

Dr. Alfano: To borrow a commercial slogan, we must be doing something right. Our enrollment keeps increasing year by year. We are up to a membership enrollment presently that is almost at three million and the trend for increasing enrollment has continued throughout the years. Something about this program is acceptable to the public. But, as you have said, we have had a diminution in our participation by physicians. That was one of the primary reasons why we had to consider a prevailing fee type of program in which we would determine what the going rates are for payment for physicians' services and that information could be obtained by no more accurate source than from the doctors themselves. What we are attempting to do now is to determine what are adequate payments. What would satisfy? In at least ninety per cent of all claims that we have received, we were satisfied with the charges made by doctors for those particular services. The medical profession would be losing its last bulwark against real socialization of medicine if we were to let the voluntary prepayment plans go.

Dr. John F. Johnson (Mercer): I have been interested in the Blue Shield programs for many years and fundamentally I agree with Dr. Moriconi. Now, you say that the Board of Trustees has given the physicians and the non-surgeons and the surgeons an opportunity to influence the decisions of the Board of Trustees. I don't think you have. I, for one, have refused to fill out the plan you sent me on fee schedules because I do not have a fixed fee. Now you want me to have a fixed fee and I will not concede that. I treat some people for nothing and I have charged as much as a thousand dollars. Now, the Board of Trustees wishes me to give you a fixed fee schedule, you will then return it to me as my return on my fixed fee schedule. Either I go along with your or I quit. And I will tell you right now I quit, because I do not have a fixed fee. I will continue to treat some people for nothing.

I am the doctor who sent in that complaint about the rehabilitation program in which Mr. Oros wanted me to do a double hernia for $220. I said to Mr. Oros I will do it for nothing but I won't take $220 for a double hernia. He sent the patient to another surgeon.

Now, somewhere along the line there has to be a certain amount of personal dignity and I will reserve the areas in which I will extend charity.

I don't think that the initial purpose of setting up the Blue Shield program any longer exists. I would suggest this, if I may, why do you not issue another complete policy which will compete on an indemnity basis with other insurance companies? Certainly the Trustees have not kept their fees up for surgeons. You're not even up to Medicare. You're not up to the State of California on which Prudential has based their Medicare surgeons' fees. Why haven't you? Why have you exceeded the original purpose for which you were created?

Now, I go back to Parkinson's Law, and I hope I'm not, Dr. Alfano, being abusive.

Dr. Alfano: No, not at all.

Dr. Johnson: I was accused of being abusive once before because I like to put my hand down on the table and call it for what it is. I think you must issue another policy, an indemnity policy. The amazing thing is, those patients who have an indemnity policy—and I may charge $175 or $200 or $225 for a single-sided hernia—think nothing of giving me that extra $50. Now, why do we sell ourselves down the river and bind ourselves to a fixed fee schedule, which is exactly what the Board of Trustees is doing? I don't think it is dignified. You are telling us what to do.

You want me to fill that program out and put one figure down. I won't even send in the second one which I got yesterday. I'm going to quit, even though in the beginning in Mercer County I fought diligently to protect the group which, as the AMA study showed, wasn't the poor and it wasn't the rich; it was the in-between. Now you are not talking about the in-between patient; you are talking about the privileged patient, and you wish to fix a schedule of fees and I don't think this is something in which the Board of Trustees represents the general practice of medicine in New Jersey.

Dr. Lloyd: Mr. Chairman, may I interrupt a moment? As a member of the Board of Trustees, I think the members of the Board of Trustees of the Medical-Surgical Plan who are here are entitled to some defense in the remarks that have been made. There hasn't been a thing said by Dr. Moriconi or Dr. Johnson that hasn't been brought up before the members of the Board of Trustees of the Medical-Surgical Plan, not once but several times.

Dr. Sprague is one of the original incorporators of this organization and has served on its board faithfully all these years. He has had considerably more agony and misgiving over the changing philosophy of this plan than Dr. Moriconi has, which was his first point—that the plan is different from what it was twenty-five years ago. And I think every other aspect of the practice of medicine and particularly the economic aspects of the practice of medicine have changed over the past twenty-five years.

When we take exception as to whether this is a service or an indemnity plan, it's too bad that Dr. Donnelly isn't here to discuss this. He is familiar with the indemnity Blue Shield plans throughout the nation. If we go into an indemnity plan, as Dr. Johnson and Dr. Moriconi have suggested, he will be one of the first to resign from that kind of plan because he thinks it's so poor.

There are all sorts of problems and every one of these points that has been brought up here tonight has been brought up and hassled over at the Board level. Many of the people who are on the staff of Blue Shield, who are not physicians have these problems thrown up to them more than once each year. We meet twelve times a year. I think we have vigorous discussions at every level.

Now, the problem of being a participating or non-participating physician—I have asked that particular question, Dr. Johnson, at the Board myself; but this will be a question of do you want to be — and I think I'm right when I say in Pennsylvania you can belong to either one or neither and I think the plan here is to propose — and I am not so sure but it is in print — that you can be a participating physician under the reasonable and customary fee and a participating physician under the service plan. You belong to both plans. Or you can belong to the service plan and not the other plan. Or you can belong to the "reasonable and customary fee" plan and not to the service plan. It will depend on the contract that the patient has how you will be affected by this. Or you can be a non-participating physician under either plan. And for the non-participating physician the Medical-Surgical Plan has always been an indemnity plan.

The prob'ems that are brought up here are medical and economic problems throughout the nation which are reflected with the problems that Blue Shield must face.

Do you want a Blue Shield plan at all? And if you don't want it, you can kill it. I would guess there is enough impetus within the organization that it will carry on in some other manner. It has grown to where it takes care of three million people in this State. That's approximately fifty per cent of the population of this State. Actually, I don't think anything that we do to kill it would actually make it die. It would just stagger for a little while and then would be completely under the control of a lay board with no medical representation there at all.

A comment was made that fees are set by

somebody who isn't interested. That person has never sat down with the fee committee. This committee meets every month. There is a committee on medical fees, a committee on surgical fees. They meet very faithfully and diligently on all the problems that come up. They don't take care of routine payments. That's made according to the contract and according to whether you participate or not.

Now, I think these points have been brought up. I think it is important that you know as individuals and as a group that these points have been under discussion at the highest level that the Medical-Surgical Plan has; namely, its Board of Trustees.

Dr. Harold C. Hardenberg (Union): Dr. Alfano, I presume with your new proposal of the ninetieth percentile, the figures that you compile, will be available to the Board of Trustees of the State Society.

Dr. Alfano: You mean the final figures as to what ranges we have determined to fall within. Yes.

Dr. Hardenberg: And this ninetieth percentile figure will fluctuate from time to time depending on the fluctuation of the prevailing fee.

Dr. Alfano: That is correct.

Dr. Hardenberg: And yet your premiums are dictated from the State. Is that right?

Dr. Alfano: Yes for the premiums; the cost for the contract, yes.

Dr. Lloyd: Isn't this experience rated?

Dr. Alfano: This *will* be experience rated. I'm sorry.

Dr. Hardenberg: If your premiums are so regulated and —

Dr. Alfano: They are not regulated.

Dr. Hardenberg: — your payments are fluctuating, how can such a system be actuarially sound?

Dr. Alfano: You mean fluctuating — just what do you mean? When we arrive at the ninetieth percentile —

Dr. Hardenberg: The ninetieth percentile will fluctuate from month to month on any given fee depending on what physicians charge that particular period for that service.

Dr. Alfano: I would like to speak on that because Dr. Johnson, made mention of the fact that here we would establish a fixed fee schedule and under certain circumstances, the doctor in his normal practice may charge nothing for one patient and a thousand dollars to another. I thought that we had clearly established in the correspondence that went out to all doctors, that this was *not* to be an inflexible program, that the fees submitted to the Plan could be changed. Under certain circumstances there could be circumstances that made the case a very difficult one and the doctor would provide a report indicating that he felt that his average fee or the fee that he had submitted to us earlier applied to the majority of patients, but here was a case that required a special consideration and it would be so given special consideration and the fee would be adjusted accordingly. So this would not be an inflexible program.

Dr. Johnson: I am for a Blue Shield program for those people who cannot afford so-called catastrophic illness. Blue Shield should insist on serving that segment of the population and I will be a participating physician in that area. I do think that you have gone beyond that. You have gone beyond the legislative privilege which we were granted, that as the third-party we would be paid directly. I understand from the insurance program what this means. But I do think you should issue a new program on an indemnity basis if you wish to put one figure down on a piece of paper as to what we charge for a standard operation. Thank you.

Dr. Alfano: Any further comments? Anyone wish to make a statement? If not, I will call the meeting adjourned.

(The meeting was adjourned at 5:30 p.m.)

DINNER DANCE

Monday Evening, May 15, 1967

Mr. Richard I. Nevin was Toastmaster. Entertainment was provided by Heidi Krall, Metropolitan Opera Soprano.

The Toastmaster:

Good evening to you, Lords and Ladies all!
Once more we gather in this noble Hall
To note the passage of another year
And pay due tribute to our leaders here.
But that anon. I summon now to view
The Lady Marion, to welcome you . . . Mrs. Marion Glazier.

(Applause)

Mrs. Jesse T. Glazier: Thank you, Mr. Nevin.

Dr. Jehl, Mrs. Jehl, Dr. Collins, Mrs. Collins, and Honored Guests: It is my pleasure and privilege to welcome you to the annual meeting, the 201st, of The Medical Society of New Jersey at the annual dinner-dance, in honor of President and Mrs. Joseph R. Jehl. This is held under the auspices of the Woman's Auxiliary, and it is our pleasure today to announce our 40th birthday. We are doubly pleased this year that we have been represented on the national level by Mrs. Asher Yaguda, who is the President of the Woman's Auxiliary to the American Medical Association, and we are very pleased that we have such an honor come to the State of New Jersey. I do hope that you enjoy the evening. Thank you.

(Applause)

The Toastmaster: I have the added privilege, ladies and gentlemen, of presenting to Mrs. Glazier, with the best wishes from the Essex County Medical Society, a bouquet.

(Applause)

(Introduction of Guests)

The Toastmaster: Ladies and Gentlemen: This is the time when the men and women of medicine seem so concerned about images that I want to share with you a story that Dr. Luke Mulligan brought back from his last trip to Ireland. It's a story of an Irishman, a farmer, who had spent all his life in rural Ireland, but who occasionaly went to market. This time when he brought his produce to market, just as he neared the town, his axle broke, so he had to stay overnight. He had never stayed overnight before at an inn. The inn was very simple; there were very few adornments. One thing that caught his eye on the dresser was a mirror that was turned face down. So he picked it up and looked at it and said: "Glory be to God, it's me father." (Laughter) And every time he came back to the room, he looked at it. "It's me father. It is indeed."

When he came the next day to check out, he sneaked the mirror into his pocket. He said: "Faith, I'll not leave the old man after me. It's home I'm taking him." So he took it home and for some reason or other he didn't share the secret with his wife. (Lots of Irishmen are not communicative.) But he got into the habit of going into the room and turning up the edge of the mattress and looking at the mirror and wagging his head in surprise and concern.

His wife caught him one time. So when he was out of the house, she went in to the room saying, "I'll find out what he's been up to." She raised the mattress and took out the mirror, looked at it, and exclaimed, "Well, if it's an old hag like that he's running around with, he can have her."

(Laughter and applause)

You see, it all depends upon who is looking at the image and interpreting it. And that brings me to the next point of our program.

Tonight in this bright hour it is our affectionate purpose to let our guest of honor — Joe Jehl — see how he is reflected in the mirror

of our hearts. His image there has no uncertain features. He shines forth clearly as a man of lofty purpose, dignity, and dauntless diligence, perceptive in intelligence, amiable of spirit . . . a good man and a worthy leader. This is how he looks to us and as he always will. This image now we acclaim; and cherish it we will through all the years.

It is now my pleasure to introduce the Peter Pan of New Jersey's medicine — a second Vernon Castle, I noticed, as he danced with my wife — Dr. John Bedrick, who, as the immediate Past-President, will induct Dr. Jehl into the most noble companionship of the Fellows of The Medical Society of New Jersey. Dr. Bedrick.

(Applause)

Dr. John J. Bedrick: We two retired fellows have a lot in common. We are over-shadowed here by a couple of Generals, so we'll leave out the Army part of our experience.

However, the presentation of a key oft has a sinister significance, but in this instance, Joe, it's the Open Sesame to the heart of the entire membership of The Medical Society of New Jersey. I know that all of them are fully aware of the great accomplishments, the great effort that you made to advance our purposes, and the fine image which you presented when you visited the medical societies of our contiguous states.

I present to you this key, and I welcome you to the comradeship of the Fellows. I know that despite the fact that this signals the beginning of the end of your presidential year, your interest in medicine and in the welfare of the Society will not flag, and I'm equally sure that your counsel will be sought and heeded. I want to congratulate you and wish you godspeed.

(Standing ovation)

Dr. Jehl: Thank you, John, and thank you, Mr. Nevin, for the kind words you have both said. I'm very happy to receive this key and to be welcomed into that very select group, one of the smallest select clubs in the world. I hope that I have done my duty. I tried. Thank you.

(Applause)

The Toastmaster: And now that he may do unto others as others have done unto him, we invite Dr. Jehl to present to Mrs. Jesse T. Glazier, as President of the Woman's Auxiliary, her Fellowette's pin.

(Applause)

Dr. Jehl: It's so nice to see you again. You know, this is the third meal we've had together today. (Laughter) We sat together for breakfast, for lunch and for dinner. You know, if my wife weren't here I might start something. Dr. Glazier is here too, so it's all right. (Laughter)

It is indeed a pleasure to have this opportunity to present this to you, Marion. I know that you have done a big job. Your efforts throughout the State have been well appreciated. The Medical Society is very proud of what you have done and I know that the Auxiliary is, too. And I welcome you into the company of the select.

(Standing ovation)

Mrs. Glazier: Thank you, Dr. Jehl. I'm deeply honored. Thank you very much.

Following Miss Krall's vocal selections . . .

The Toastmaster:

Thus Art and Beauty join to give us such
Delight as never life affords too much.
The spell must break, and soon we must
depart,
Enriched by mem'ries grateful to the heart.
Ere you fare forth to end the happy trance,
My Lords and Ladies, rise and join the dance!

Scientific Exhibit Awards

At the 201st Annual Meeting of The Medical Society of New Jersey, seven awards were presented to physicians for their scientific exhibits.

The highlight of the ceremony was the presentation of the "Aesculapius Award," provided by the Mead Johnson Laboratories. The award, presented by Joseph R. Jehl, M.D., included a plaque inscribed with the title of the exhibit, the authors names, and a $200 cash prize. The winning exhibit, selected by a committee of The Medical Society of New Jersey, was "Hemodialysis At Home" by Norman Deane, M.D., with Ginette Jacob, M.D. and Peter Missier, M.D. of New York.

The second award was presented for "Reconstructive Middle Ear Surgery – Tympanoplasty" by Julio T. Noguera, M.D., F. Robert Haase, M.D., and William H. Petersen, M.A., Jersey Shore Medical Center, Neptune City.

Honorable Mention Certificates were presented to the following:

"The Delayed Effects Of Low Dose, Internally Emitted, Radiation" by Carye-Belle Henle, M.D., Hyman Fisher, M.D., Samuel Ingraham, M.D., and Robert Bonda, D.D.S., Radium Research Project, New Jersey State Department of Health, West Orange

"Urinary Tract Infections In Children – Diagnosis And Treatment" by Donald E. Praiss, M.D., and Willard M. Drake, Jr., M.D., Cooper Hospital and Our Lady of Lourdes Hospital, Camden

"Abnormal Intestinal Rotation And Fixation – The Importance Of Roentgen Diagnosis In Infants And Children" by James R. Marquis, M.D., John W. Marquis, M.D., Frederick Strauss, M.D., and Eugenia Karvouni, M.D., Babies Hospital Unit, United Hospitals of Newark

"The Spleen – New Concepts Of It's Function" by Eric J. Lazaro, M.D., Albert H. Levy, M.D., Laurence P. Parmer, Ph.D., and Albert Schnerring, New Jersey College of Medicine and Dentistry, and Veterans Administration Hospital, East Orange

"Current Diuretic Armamentarium: Clinical And Pharmacologic Appraisal" by Albert N. Brest, M.D., Gaddo Onesti, M.D., Robert Seller, M.D., Osvaldo Ramirez, M.D., Charles Swartz, M.D., and John H. Moyer M.D., Hahnemann Medical College and Hospital, Phila., Pa.

Chairmen of Councils and Committees — 1967-68

Air Pollution Control
Roslyn Barbash, M.D., Teaneck
Annual Meeting
Jerome G. Kaufman, M.D., Maplewood
Cancer Control
John L. Olpp, M.D., Englewood
Child Health
William J. Farley, M.D., Nutley
Chronically Ill and Aging
Matthew E. Boylan, M.D., Jersey City
Conservation of Vision
Frank B. Vanderbeek, M.D., Paterson
Credentials
Marcus H. Greifinger, M.D., Newark
Emergency Medical Care
Jack R. Karel, M.D., Hillside
Honorary Membership
Ralph M. L. Buchanan, Phillipsburg
Legislation
Jesse McCall, M.D., Newton
Maternal and Infant Welfare
John D. Preece, M.D., Trenton
Medical Defense and Insurance
Fred A. Mettler, M.D., Blairstown
Medical Education
Sherman Garrison, M.D., Bridgeton
Medical Services
Nicholas E. Marchione, M.D., Vineland
Medical Student Loan Fund
Luke A. Mulligan, M.D., Leonia
Medicine and Religion
Jerome G. Kaufman, M.D., Maplewood
Mental Health
Robert S. Garber, M.D., Belle Mead
Occupational Health, Workmen's Compensation, and Rehabilitation
Joseph A. Lepree, M.D., Elizabeth
Public Health
John P. Coughlin, M.D., Jersey City
Public Relations
Harry F. Suter, M.D., Penns Grove
Publication
George B. Sharbaugh, M.D., Trenton
Retirement Plan For Physicians
Nicholas E. Marchione, M.D., Vineland
Revision of Constitution and By-Laws
Louis F. Albright, M.D., Spring Lake
Scientific Exhibits
Milton Ackerman, M.D., Atlantic City
Scientific Program
James A. Rogers, M.D., Paterson
Woman's Auxiliary
George O. Rowohlt, M.D., Dumont

ATTENDANCE

REGISTRATION OF HOUSE OF DELEGATES

Registration:			
Total Possible—Officers, Fellows, and County Delegates			368
Total Possible of County Delegates		349	100%
Total County Delegates Registered		335	96%

Attendance of County Delegates at the House Sessions:		% of Possible	% of Registered
1st Session, 5/13/67	(288)	82.2%	85.4%
2nd Session, 5/14/67	(312)	89.4%	93.1%
3rd Session, 5/16/67 A.M.	(290)	82.8%	86.3%
P.M.	(261)	74.5%	77.6%
Average for all Sessions	(288)	82.2%	85.4%

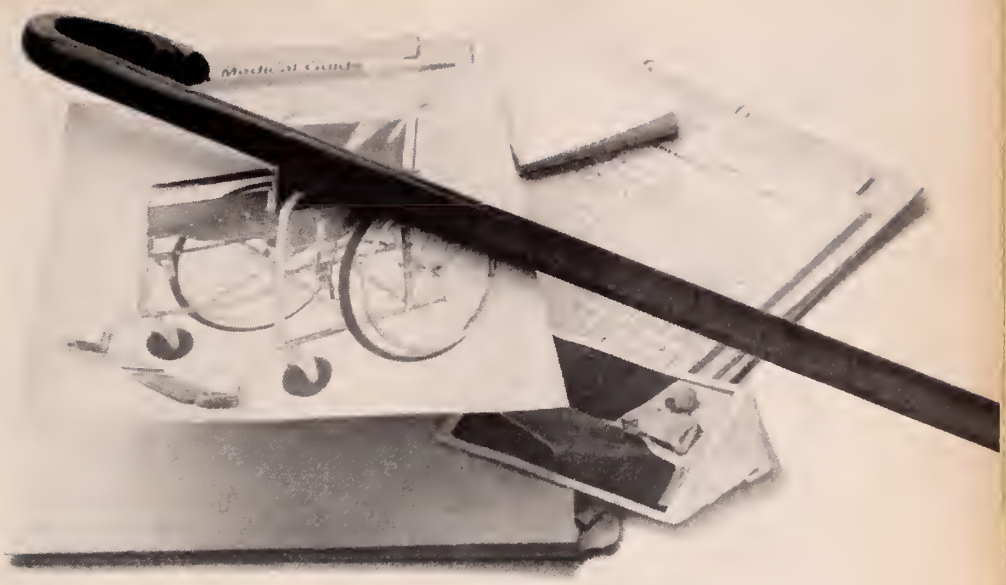
Official Attendance Report

County	Delegates	Members	Total
Atlantic	8	52	60
Bergen	38	29	67
Burlington	8	16	24
Camden	20	30	50
Cape May	3	3	6
Cumberland	5	13	18
Essex	66	119	185
Gloucester	4	20	24
Hudson	28	30	58
Hunterdon	1	1	2
Mercer	23	42	65
Middlesex	18	22	40
Monmouth	17	40	57
Morris	16	22	38
Ocean	6	14	20
Passaic	29	28	57
Salem	3	13	16
Somerset	6	7	13
Sussex	3	3	6
Union	30	58	88
Warren	3	4	7
Fellows and Officers	16	—	16
	351	566	917

Physician Guests	79
Physician Exhibitors	21
TOTAL PHYSICIAN REGISTRATION	1,017
Auxiliary	419
Visitors	337
Exhibitors	262
TOTAL REGISTRATION	2,035

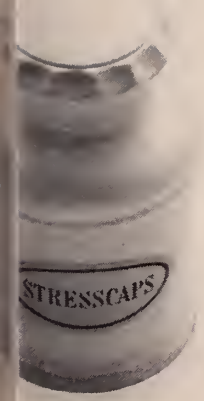
FIVE-YEAR COMPARATIVE REGISTRATION FIGURES

Year	Physicians	Others	Total
1967	1,017	1,018	2,035
1966	1,024	1,135	2,159
1965	1,019	1,046	2,155
1964	1,040	966	2,006
1963	1,018	973	1,991



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Each capsule contains:

Vitamin B_1 (as Thiamine Mononitrate)	10 mg
Vitamin B_2 (Riboflavin)	10 mg
Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Vitamin C (Ascorbic Acid)	300 mg
Niacinamide	100 mg
Calcium Pantothenate	20 mg

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

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MEDICARE'S FIRST YEAR

Now that Medicare's initial year has become history, it may be belaboring the obvious to say that never has there been a year of such upheaval and change in health care protection. The impact of Medicare, like the ripples from a stone dropped in a pond, has spread in all directions.

Medical-Surgical Plan, though not directly involved as a Medicare carrier, has felt this impact in several ways.

The Blue Shield Prevailing Fee program, which soon will become operative in New Jersey for certain experience-rate national accounts, received great impetus from Medicare's espousal of "reasonable charges" payments. It is a foregone conclusion that more and more persons under 65 will demand the Medicare type of program. If the private sector does not provide it, it's a pretty safe bet that the government will.

The advent of Medicare presented Medical-Surgical Plan with the opportunity—obligation, if you will—to maintain for them the level of coverage its subscribers enjoyed before they became 65 and were taken under the wing of government. Filling Medicare's deductible and co-insurance gaps required new approaches, new procedures, new techniques. The ultimate actuarial impact of these is not yet known, but it may be far-reaching. It has been necessary to assume an unknown liability—unknown because it is based upon payments that are determined by another carrier.

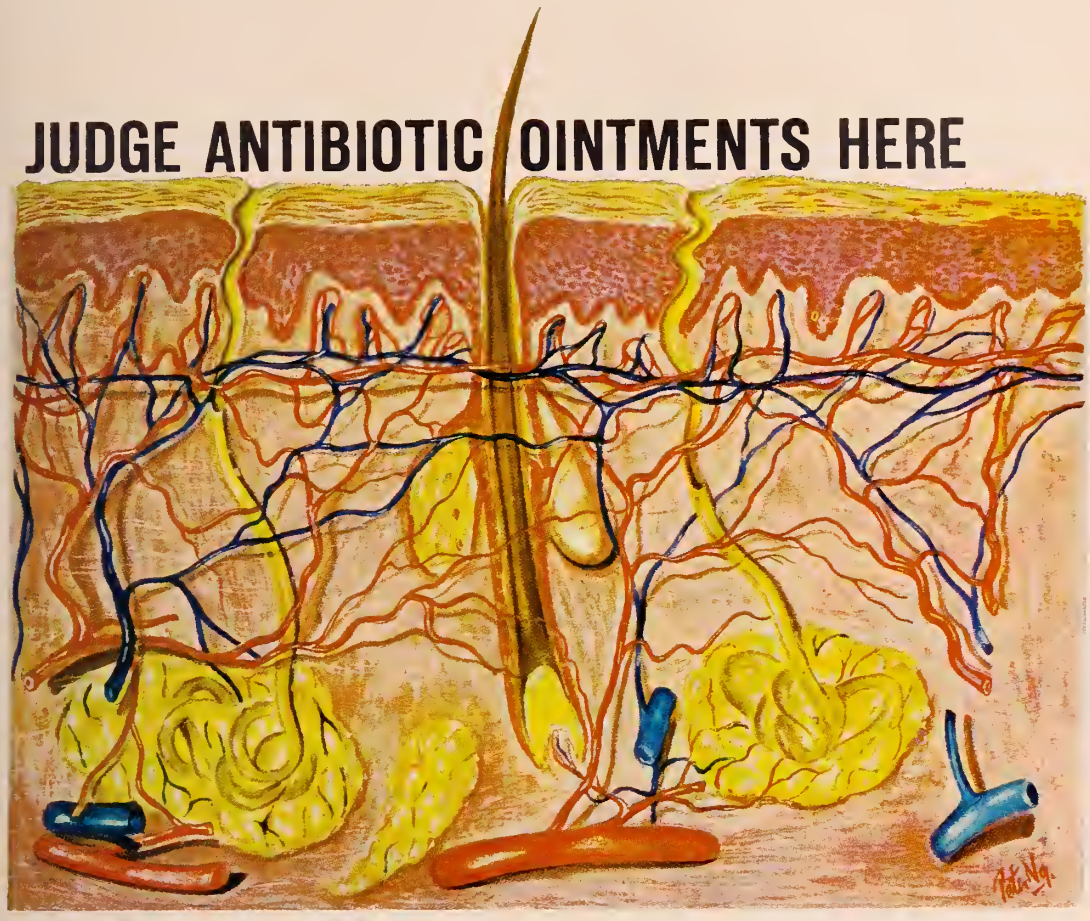
Another problematical impact of Medicare is associated with the possible offering of an extended benefits Rider—similar to Rider J, but without medical care benefits—to members enrolled in the "Blue Cross-Blue Shield 65" program that complements Medicare. Ordinarily, Riders are offered only to enrolled Groups, where the actuarial risk is spread. In this instance the Rider would be offered to a high-age, high-utilization class of individuals, a situation known in insurance parlance as "adverse selection."

Unquestionably the impact of Medicare on Medical-Surgical Plan's voluntary prepayment approach will continue to grow—especially if government participation of health care protection grows, which appears likely.

Medicare's first year has demonstrated that Blue Shield must continue to embark upon new approaches, adopt new payment mechanisms, provide wider coverages, if it is to survive galloping federalization of health care protection. and continue to serve the medical profession as its chosen instrument for voluntary prepayment. To do so it must have the full and active support of the profession as Participating Doctors.

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MEDICAL-SURGICAL PLAN OF NEW JERSEY
500 Broad Street, Newark

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Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

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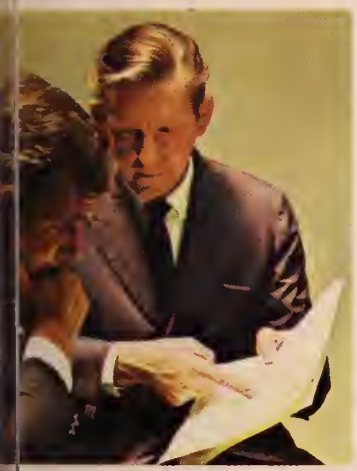
Why these 7 patients wi
moderate to severe anxie
may respond better to Mella



1. The agitated patient.
Anxiety—particularly that bey
range of minor tranquilizer
quently is expressed as gross
restlessness, fidgetiness and p
less movements, and may eru
aggressive behavior. Mellari
most a specific for those p
whose anxiety follows such a p



psychosomatic patient.
ily physician is rarely given
gnostic luxury of a classic,
k "anxiety state." Most often
probe for anxiety masked by
onal disorder – or which exac-
a somatic problem. Double-
aluations have demonstrated
llaril can be a significant ad-
the treatment of such patients.



patient under
onal stress.
helps the patient deal with
of everyday life. Nonhabitu-
can be given for extended pe-
time. It does not "separate"
ent from practical problems
sures, does not induce eupho-
fuzziness which can compro-
ne ability to cope with reali-
Rather, it helps the patient
e more competently in his
ly world by eliminating use-
ss tension, by allowing him to
onserve emotional resources
and energies, and to direct
them against the problems
really worth worrying about.



4. The menopausal patient.
The woman who sees change of life as the end of useful life requires support from both family and family physician. Whether the psychological impact of menopause is directly related to hormonal changes, or merely coincidental, is debatable, but estrogenic therapy is frequently inadequate. Mellaril is a useful aid for these patients and, alone, or in combination with reduced estrogen dosage, will help ease the menopausal misery.



5. The previously hospitalized psychiatric patient.
Such a patient may still require the type of medication he has been accustomed to, but because he is no longer in a controlled setting the acceptable level of adverse reactions must be lower. In such circumstances Mellaril is perhaps the drug of choice.



6. The agitated geriatric.
Tranquilizer therapy in the elderly patient always involves special (or at least accentuated) problems: the possibility of drug-induced ataxia, hypotension or depression, for example, assumes an additional significance. These reactions have rarely been observed in geriatric patients treated with Mellaril.



7. The constantly returning patient.
The anxiety patient who has not responded to a minor tranquilizer is not very likely to benefit from your minor tranquilizer of second choice. A major tranquilizer, such as Mellaril, may be indicated in such patients.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.
Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.
Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.
Before prescribing, see package insert for full product information.

in moderate to severe anxiety, 25 mg. t.i.d.

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Bladder
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Flagyl seeks out the sites where trichomonads hide. Only a systemic agent can. Flagyl does, selectively and effectively.

Flagyl destroys trichomonads in the inner crypts, glands and cavities of the genitourinary tract in both women and men. Consequently, Flagyl is capable not only of curing trichomoniasis in women but also of preventing reinfection.

Correctly used, with due attention to repeat courses of treatment for resistant, deep-seated invasion and to the presumption of reinfection from male consorts, Flagyl has repeatedly produced up to 100 per cent cure in large series of patients.

When the diagnosis of trichomoniasis is positive, Flagyl is positive.

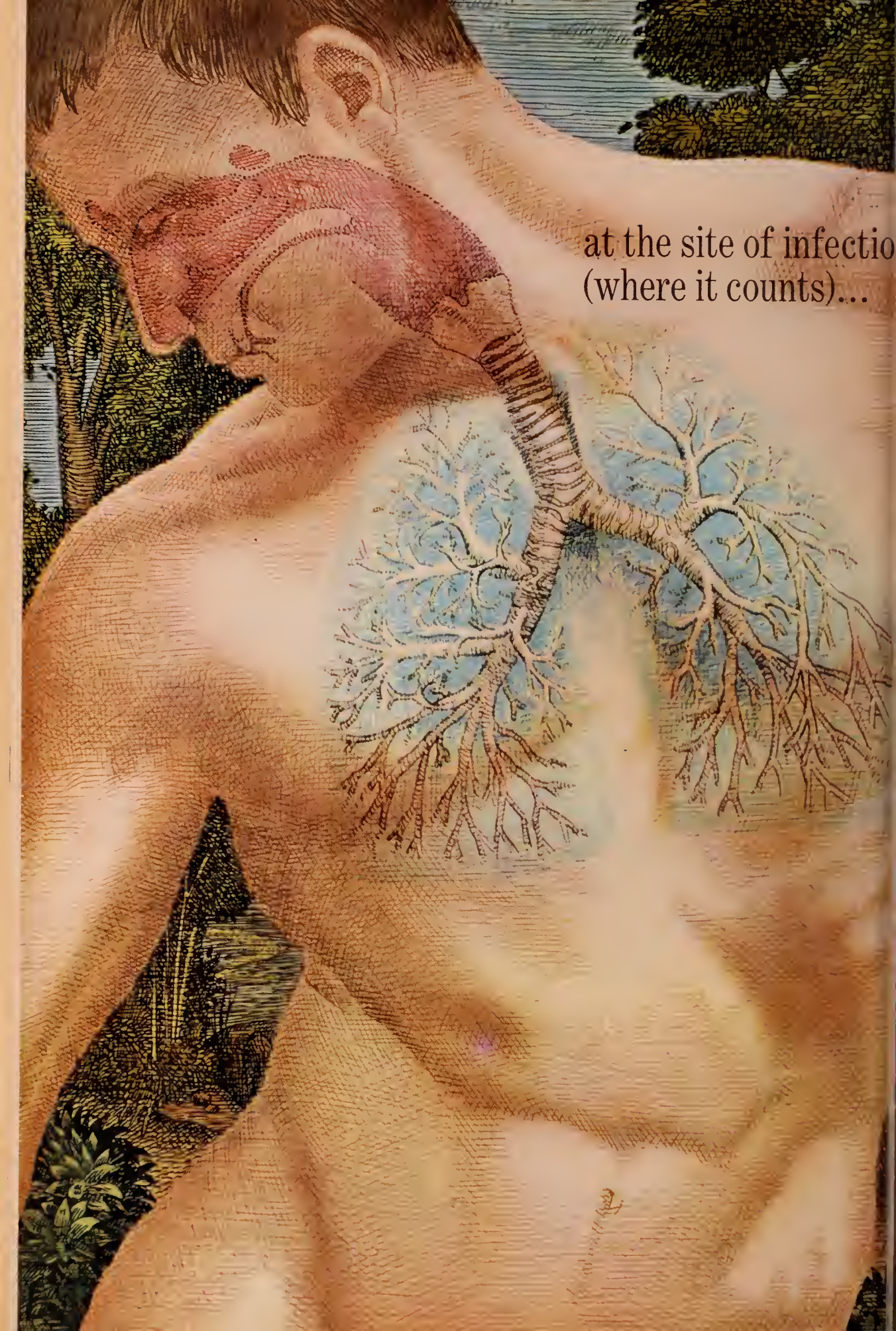
Dosage and Administration—In *women:* one 250-mg. oral tablet three times daily for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.
In *men* in whom trichomonads have been demonstrated: one 250-mg. oral tablet twice daily for ten days.

Contraindications — Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precaution—Complete blood cell counts should be made before, during and after therapy, especially if a second course is necessary.

Side Effects—Infrequent and minor side effects include nausea, metallic taste, furry tongue and headache. Other effects, all reported in an incidence of less than 1 per cent, are diarrhea, dizziness, vaginal dryness and burning, dry mouth, rash, urticaria, gastritis, drowsiness, insomnia, pruritus, sore tongue, darkened urine, anorexia, vomiting, epigastric distress, dysuria, depression, vertigo, incoordination, ataxia, abdominal cramping, constipation, stomatitis, numbness of an extremity, joint pains, confusion, irritability, weakness, flushing, cystitis, pelvic pressure, dyspareunia, fever, polyuria, incontinence, decreased libido, nasal congestion, proctitis and pyuria. Elimination of trichomonads may aggravate candidiasis.

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Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

Now available:
New! Ready-mixed Ilosone Liquid 125! (Contains erythromycin estolate equivalent to 125 mg. erythromycin base per 5-cc. teaspoonful.)

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Ilosone®
Erythromycin Estolate

Lilly

(See next page for prescribing information.)

Ilosone®/ the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have also been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Adverse Reactions: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have developed in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly, usually within forty-eight hours, if the drug is readministered to sensitive patients. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrcquent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appe be definitely related to use of the drug, laboratory findin characterized by increased direct-reacting bilirubin, alkaline phosphatase levels, negative or weakly positive flocculation and thymol turbidity tests, elevated serum g oxalacetic transaminase levels, peripheral eosinophilia, a mal cholecystograms.

Individual idiosyncrasy seems evident since jaundice been reported in other patients taking prolonged course medication. Patients with chronic infection have been gi to 2 Gm. of the drug daily for periods of two to six mon patients with rheumatic fever have taken prophylactic 0.5 Gm. daily for two years without difficulty. In one g 144 patients who received the drug daily for two years, dice was noted. It was of interest that members of six patients' families, who were not taking the drug, had of jaundice during the study period.

Transaminase and serum alkaline phosphatase leve determined in a group of fifty-four adults and children w 250 mg. of Ilosone daily for an average of sixteen mo rheumatic fever prophylaxis. The results were compar those of a similar group of forty-four patients who recei icillin. There were no cases of jaundice in either group. E of SGPT and serum alkaline phosphatase levels during th of treatment was observed in one patient treated with and in two patients treated with penicillin. Seven other in the group receiving Ilosone and four others in the p group showed elevations in one of the tests at some time administration of the drugs.

Very satisfactory therapeutic results, without toxici reported in 102 pediatric patients who received short-ter day) courses of Ilosone in the treatment of streptococc tions. Results of liver function tests in these patien comparable to those in a similar control group who had penicillin.

Gastro-intestinal disturbances not associated with he fects are observed in a small proportion of individuals as of a local stimulating effect of the medication on the ali tract; however, the normal intestinal gram-negative flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with of erythromycin, there have been occasional reports of u skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered ora Ilosone Pulvules®, Ilosone Liquid 125, Ilosone, 125, Suspension, Ilosone Drops, Ilosone Chewable Tablets.

For infants and for children under twenty-five pounds weight, the usual dosage is 5 mg. per pound every six ho children twenty-five to fifty pounds, 125 mg. every si (Tablets Ilosone Chewable should be chewed or crus swallowed with water.)

For adults and for children over fifty pounds, the usua of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral eryth therapy should be considered.

In the treatment of syphilis, the recommended total 20 to 30 Gm. given in divided doses for a period of ten days. Close follow-up of the patient is necessary since mycin drugs have not had adequate evaluation in all s syphilis. Examinations of spinal fluid are recommende of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four recommended. In the treatment of gonorrhea, patient suspected lesion of syphilis should have a dark-field exa before receiving antibiotics, and monthly serologic test be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and (equivalent to base), in bottles of 24 and 100.

Ilosone Liquid 125, Oral Suspension, U.S.P., 125 mg. (e to base) per 5-cc. teaspoonful, in 60-cc. and pint-size

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (e to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 1 packages, with dropper calibrated at 25 and 50 mg.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent in bottles of 50.

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., 2
2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., 1
3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 1960.

Additional information available to physicians upon request.

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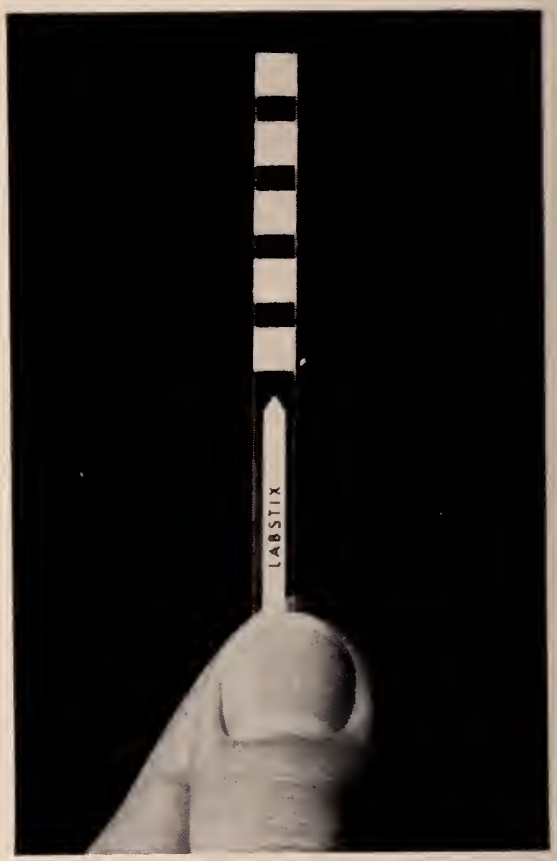
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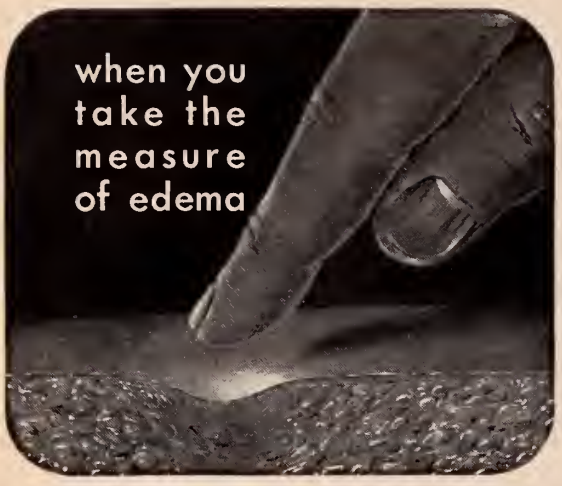
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DIURETIC ACTION: Clinically, the oral administration of AQUATAG (benzthiazide) results in diuretic activity within two hours with maximal natriuretic, chloruretic, and diuretic effects occurring during the fourth, fifth and sixth hours. Maintenance of response continues for approximately 12 to 18 hours. Acidosis is an unlikely complication since therapeutic doses of AQUATAG (benzthiazide) do not appreciably increase bicarbonate excretion. Edematous patients receiving 50 mg. of AQUATAG (benzthiazide) daily for five days developed a maximal increase in the rate of sodium excretion on the first day, and maintained this high rate until depletion of excessive body stores of sodium.

In congestive heart-failure patients, AQUATAG (benzthiazide) produced the same weight loss, during a 48-hour treatment period as did a maximally effective dose of hydrochlorothiazide.

DOSAGE: Diuresis, initially 50 to 200 mg.; maintenance 25 to 150 mg., daily. Hypertension 50 to 100 mg. initially, adjusted to 50 mg. t.i.d. or downward to minimal effective dosage level.

WARNINGS: Use with caution in the presence of renal disease as azotemia may be precipitated or increased. In patients with advanced hepatic disease, electrolyte imbalance may result in hepatic coma. Dosage of coadministered antihypertensive agents should be reduced by at least 50%. In cases of suspected electrolyte imbalance, serum electrolyte determinations should be performed and imbalance, if any, corrected. Stenosis or ulcer of small intestine have been reported with coated potassium formulas, and surgery has been required and deaths have occurred. Based on surveys of both United States and foreign physicians, incidence of these lesions is low and a causal relationship in man has not been definitely established. Until further experience has been obtained, the use of the drug in pregnant patients should be weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or dysfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties. Severe hepatic disease is a relative contraindication. (See "Warnings" above.)

PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia (digitalis toxicity may be precipitated), hypochloremic alkalosis and hyponatremia may occur.

Patients with cirrhosis should be observed for impending hepatic coma and hypokalemia. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Hepatic fetor, tremor, confusion and drowsiness are signs of impending pre coma and coma in patients with cirrhosis. Insulin requirements may be altered in diabetes. AQUATAG (benzthiazide) should be used with caution post-operatively as hypokalemia is not uncommon. Potassium supplementation may be advisable pre- and post-operatively. There have been occasional reports of thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia and precipitation of acute pancreatitis or jaundice.

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Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: The initial daily dosage in adults is 300-600 mg. in divided daily doses. When improvement occurs, dosage should be decreased to the minimum effective level; this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

For complete details, please refer to full prescribing information. 6562-VI(B)R

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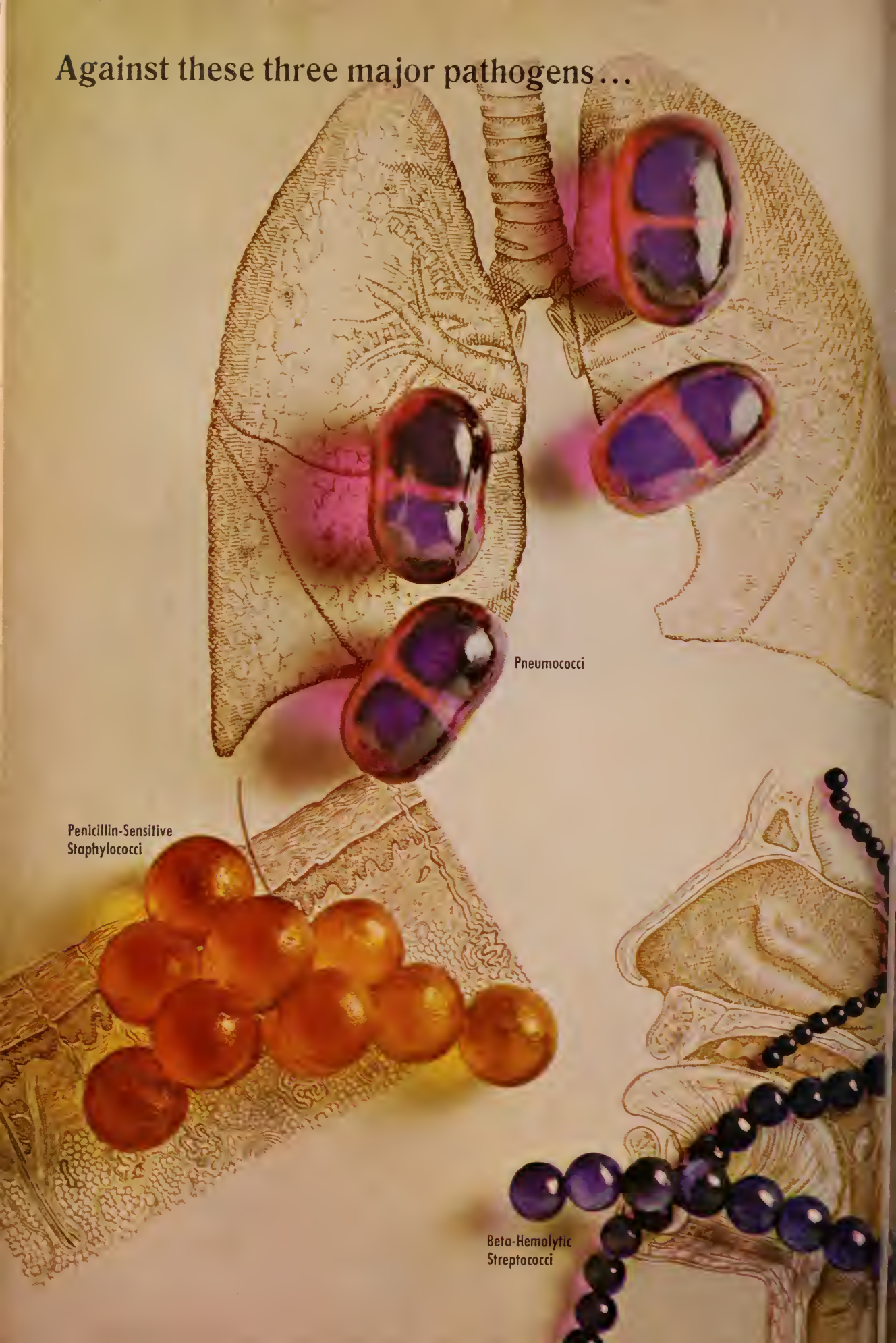
3 out of 4 osteoarthritics completely or markedly improved

Sperling, I.L.: 3 Years' Experience with Oxyphenbutazone in the Treatment of Rheumatic Disorders, Applied Therapeutics 6:117, 1964.	76.9% of 407 patients
Watts, T.W., Jr.: Treatment of Rheumatoid Disorders with Oxyphenbutazone, Clin. Med. 73:65, 1966.	84.6% of 39 patients

Please see adjoining page for brief prescribing summary.

TA-4919 PC

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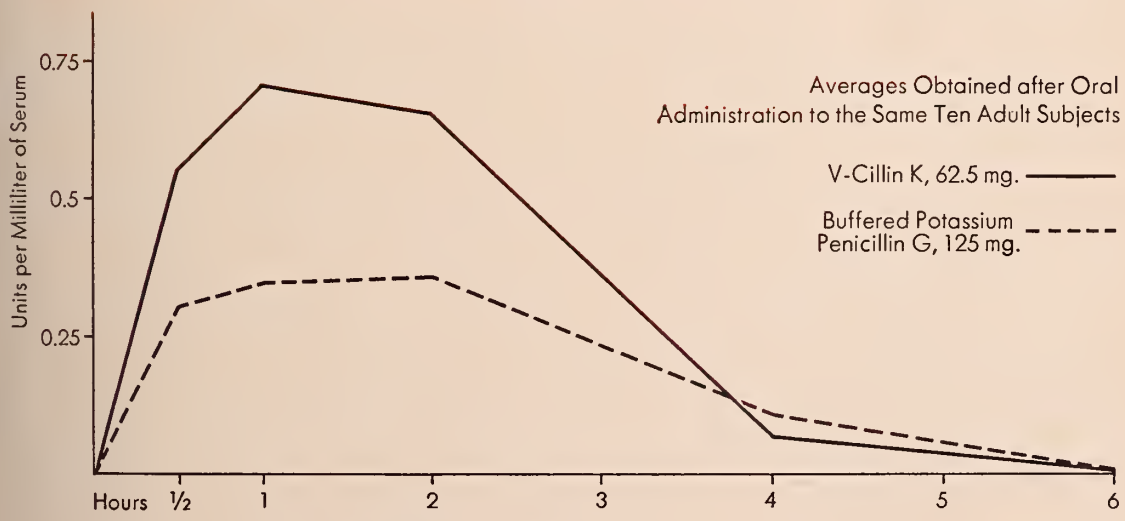
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Antibiotic	Staph. Aureus (Penicillin-Sensitive) MIC (mcg./ml.) Median	Range	Streptococcus, Group A MIC (mcg./ml.) Median	Range	Diplococcus Pneumoniae MIC (mcg./ml.) Median	Range
Penicillin V	0.02	0.02-0.04	0.02	0.003-0.4	0.01	0.005-0.2
Penicillin G	0.02	0.005-1.6	0.005	0.002-0.2	0.02	0.01-0.1
Methicillin	1.6	0.4-6.3	0.2	0.1-0.4	0.2	0.1-1.6
Oxacillin	0.4	0.1-3.1	0.04	0.02-0.4	0.1	0.04-0.8
Cloxacillin	0.2	0.2-0.8	0.1	0.1-0.8	—	—
Nafcillin	0.4	0.2-0.8	0.04	0.02-0.1	0.02	0.02-0.2
Ampicillin	0.2	0.1-0.8	0.02	0.01-0.04	0.02	0.01-0.04

Adapted from Klein, J. O., and Finland, M.: New England J. Med.,269:1019, 1963.

with high blood levels, even in the presence of food



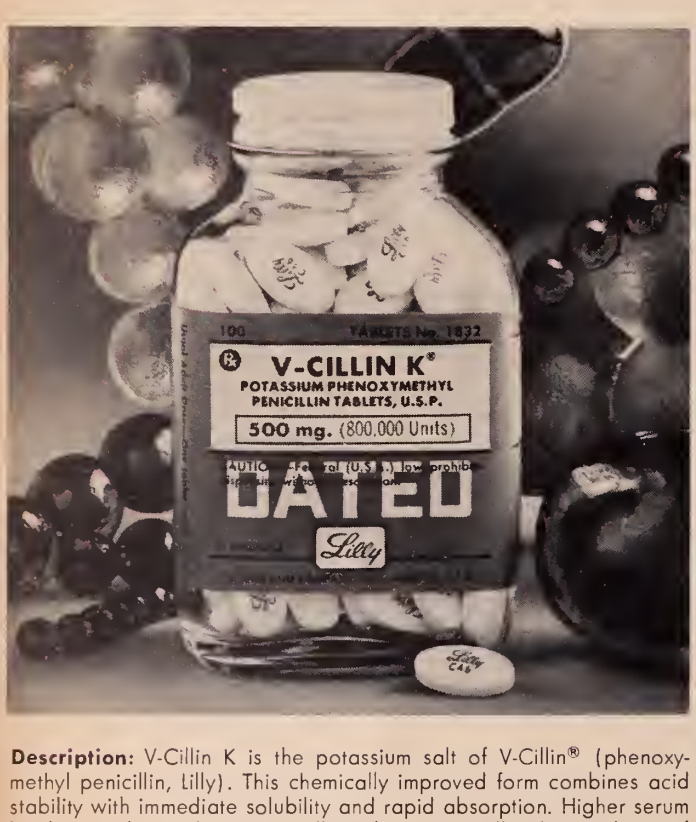
Adapted from Griffith, R. S., and Black, H. R.: Current Ther. Res., 6:253, 1964.

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(See next page for prescribing informatio

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Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Warnings: In rare instances, the use of penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin and in those with bronchial asthma or other allergies. Resuscitative drugs should be readily available for emergency administration. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for relief of immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

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In suspected staphylococcus infections, proper laboratory (including sensitivity tests) should be performed.

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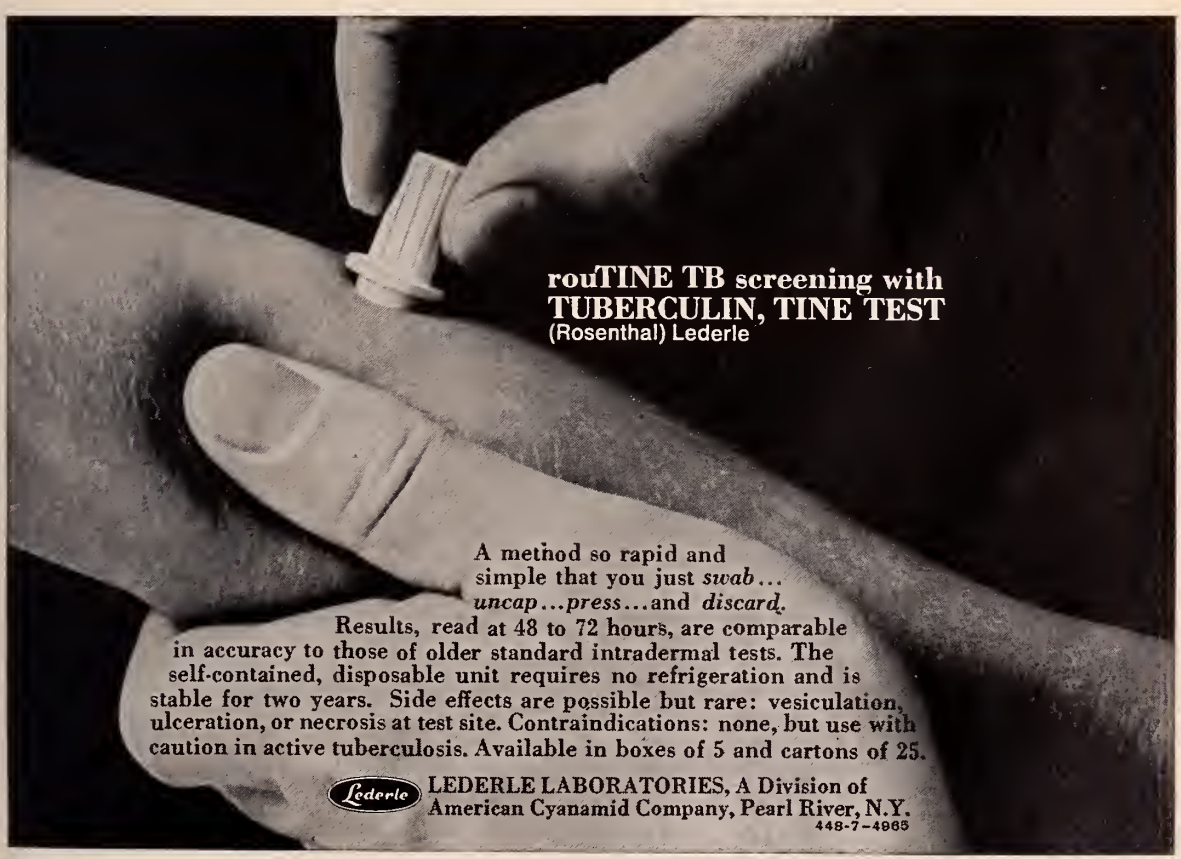
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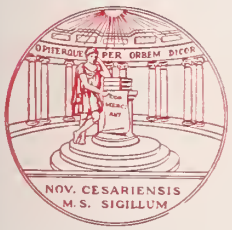
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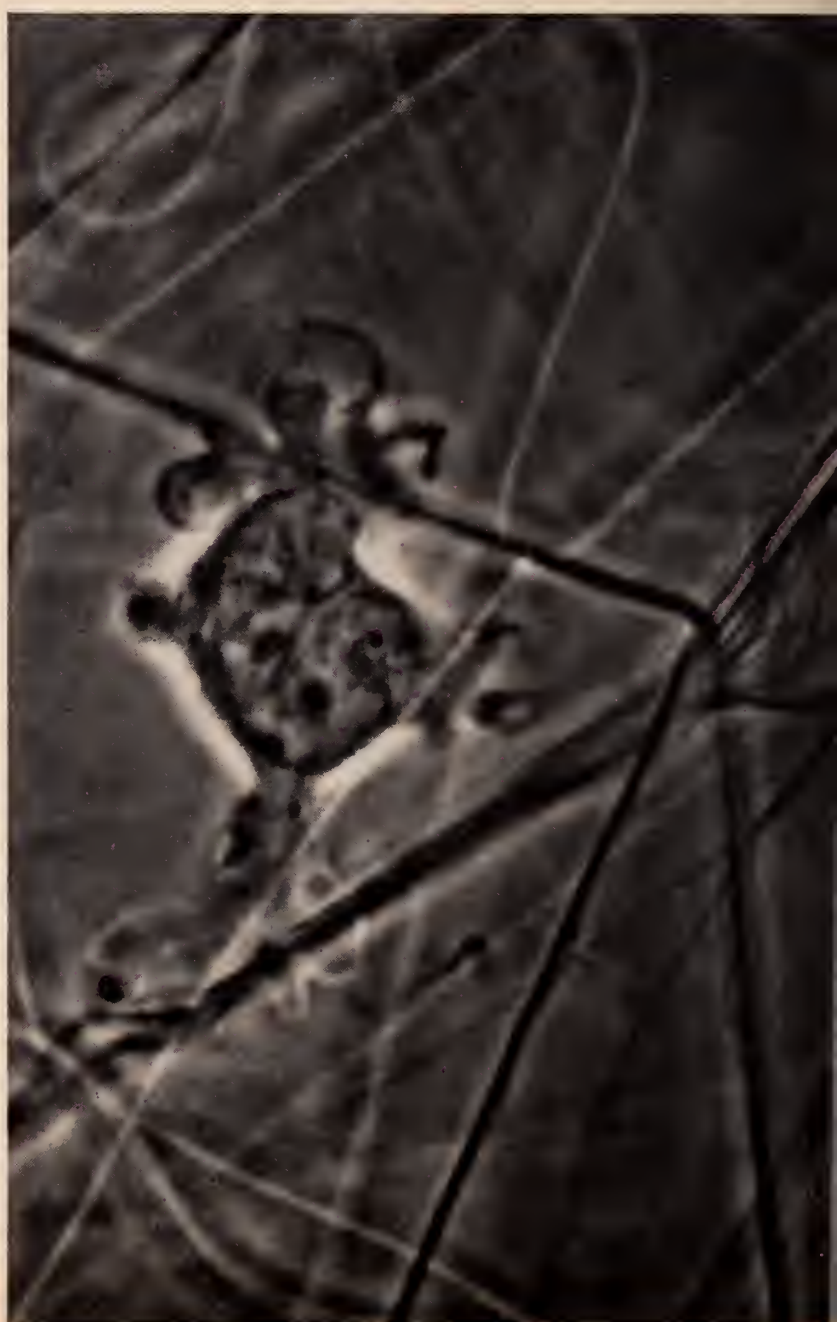
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INFLAMMATION:
A cellular fight for life

A SYNTEX REPORT based on recently developed hypotheses about topical corticosteroids, including the cellular theories of inflammation by Thomas F. Dougherty, Ph.D., University of Utah.

You are looking at a fibroblast fighting for life. This cell—one of the most common found in connective tissue—has literally been poisoned by cytotoxins released from other cells that have ruptured. Soon, if the abnormal activity of this fibroblast does not cease, it, too, will rupture and die—one more casualty in the inflammatory wave of destruction precipitated by injury.

Until a short time ago no one had ever witnessed such a scene at the cellular level. Now, through advanced cinemicrographic techniques, it is possible to view and photograph the inflammatory process as produced experimentally in living animal tissue. This method permits new insight into the mechanism of inflammation and the role of corticosteroids in therapeutic management. Equally important, these techniques shed new light on factors that may make one corticosteroid more effective than another—factors that can be correlated with other chemical, biologic, and clinical parameters.

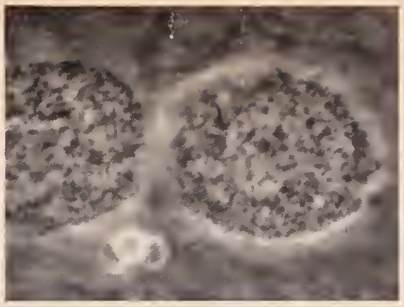


Visual evidence of how corticosteroids influence the inflammatory reaction

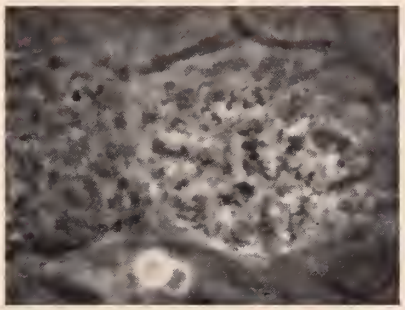
Working with phase-contrast cinemicrography on living animal tissue, Doctors Thomas F. Dougherty and David Berliner of the University of Utah College of Medicine have actually filmed cellular events that occur during the inflammatory reaction. This remarkable study* and additional work by these investigators, as well as by others, have established a new theoretical biologic basis for the antiinflammatory effect of the corticosteroids. (It must be noted that other theories, such as the lysosome or so-called "suicide bag" theory, have been postulated, although it is quite likely that there are more similarities than differences among the various theoretical models.)

The inflammatory wave of destruction

In this investigation an injurious injection of gelatin is used to set off an inflammatory reaction in living mouse tissue. What follows is a wave of destructive cellular activity that comprises the inflammatory response to injury. Mast cells (which contain heparin, serotonin and histamine) take up water, swell and rupture, releasing their contents, which are toxic outside the mast cell wall. These toxins, in turn, cause disintegration of other cells (such as fibroblasts) and the release of additional toxic material. Capillaries, too, take up water and leak unformed blood elements, causing edema. And polymorphonuclears, lymphocytes and perithelial cells invade the inflamed site. As a result of all these changes, the cellular environment reaches a state of turmoil.



Phase-contrast microscopy showing mast cell before injury.



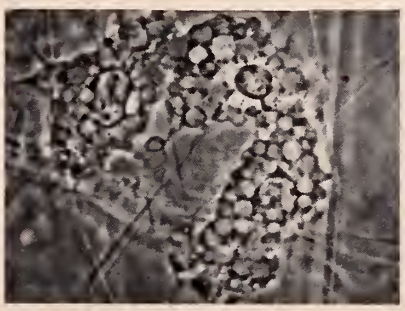
Mast cell (after injury) has broken up and released cytotoxins.

How corticosteroids change the picture

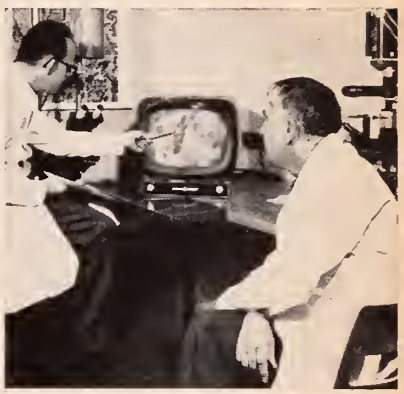
Corticosteroids appear to virtually stop the abnormal cellular activity that constitutes the inflammatory reaction. This permits the body's natural resources to clear up the inflamed area and repair the damaged tissue. This interpretation is supported by the fact that when the injurious gelatin solution is injected simultaneously with a corticosteroid – Synalar (fluocinolone acetonide) – the inflammatory pattern simply does not develop.



Fibroblast in high state of activity, much distorted.



Mast cells showing effects of corticosteroid action: cells are normal in size, shape and activity.



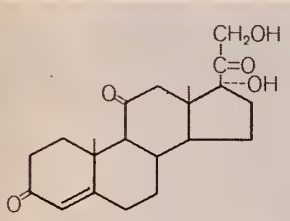
In summarizing his study Doctor Dougherty states: "...we also feel this work may explain why one corticosteroid helps a patient more rapidly and effectively than another. If it does, it is because one corticosteroid is the fastest, most effective inhibitor of the series of inflammatory events at the tissue level."

**A New View of Corticosteroid Action in Inflammatory Dermatoses*, a film based on this study, is now available from your Syntex representative.

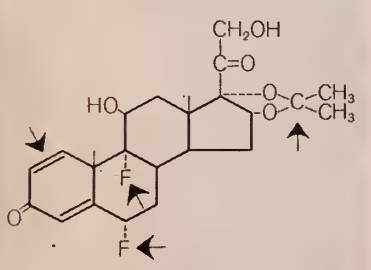
See last page for contraindications, precautions, side effects and dosage

How advances in chemical design have achieved greater steroid potency

The chemical modification of corticosteroid molecules from the advent of hydrocortisone to the development of Synalar (fluocinolone acetonide) is a prime example of how biochemists can "design" to increase therapeutic activity and minimize undesirable side actions. Below, for example, we see the important changes that were made in reference to the hydrocortisone molecule to produce fluocinolone acetonide, one of the most active of all topical corticosteroids. As a result, a 0.01% preparation of Synalar (fluocinolone acetonide) has been reported to do the work of a 1% hydrocortisone product containing 100 times more cortiscosteroid. And it can often do it more effectively.



Hydrocortisone

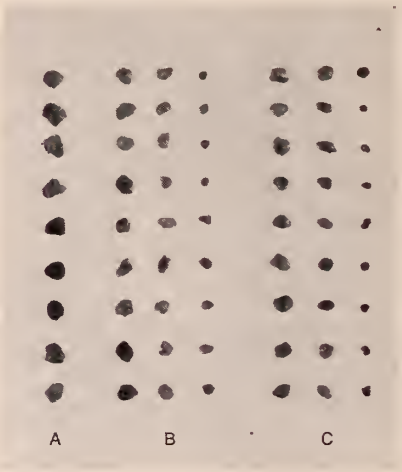


Fluocinolone Acetonide (Synalar)

- ☐ *a double bond between carbons 1 and 2*
- ☐ *fluorine substitutions at* both *the 6-α, and the 9-α positions*
- ☐ *the addition of the acetonide at the 16-α, 17-α positions, thus providing one of the most potent topical corticosteroids available.*

How bioassay tests are used to "predict" therapeutic potential

Biologic assays are another tool used by researchers to help establish the relative activity of corticosteroids. To date no single method of assaying corticosteroid activity has emerged as the ideal "yardstick" for predicting therapeutic potential. Taken together, however, these methods have proved useful. When such tests are run on various corticosteroids, a definite order of corticosteroid activity becomes evident. Compounds with the highest order of activity may be expected to merit clinical trial to establish their high therapeutic potential. When assayed by these methods, fluocinolone acetonide (Synalar) emerges as one of the most active topical corticosteroids, milligram for milligram, available for clinical application today.



THE THYMUS INVOLUTION ASSAY[1-4] is run on adrenalectomized rats. The sizes of the glands are measured, and the degree of involution caused by the steroid is determined as an indication of its potency. In the above photo, the comparative involution of thymus glands achieved with hydrocortisone and Synalar (fluocinolone acetonide) is shown. Untreated controls (A) show normal size. Group B – injected with 1, 2 and 4 mg. of hydrocortisone – show progressively smaller thymuses as does Group C – injected with fluocinolone acetonide – but with only 1/500th the dose of hydrocortisone.



THE ANTIGRANULOMA ASSAY[1-4] also utilizes adrenalectomized rats. Granulomas are induced by subcutaneous implantation of cotton pellets on either side of the thorax. The degree of granuloma inhibition achieved by a steroid reflects its potency. The above photo shows the inhibition of granuloma formation achieved with hydrocortisone and Synalar (fluocinolone acetonide). Untreated controls (A) show large, red granulomas adhering to the pellets. Group B, receiving hydrocortisone and Group C, receiving fluocinolone acetonide, show little, if any, granuloma formation. Fluocinolone acetonide produced the same effect as hydrocortisone with only 1/500th the dose. This assay, as well as the thymus involution assay, measures systemic rather than topical corticosteroid activity. Nevertheless, results by these methods correlate well with other assays and with the milligram potencies of topical steroids in current clinical use.

Worldwide clinical experience confirms the predictable therapeutic potential of Synalar

It is particularly gratifying that the promise of the advanced chemical design and high order of bioassay activity of Synalar (fluocinolone acetonide) has been confirmed by widespread therapeutic application. Indeed, the impressive clinical response rate of Synalar has been documented in no fewer than 232 papers from 22 countries.

Representative Clinical Results with Synalar*

Efficacy Documented in over 4,000 Patients

Condition	Number of Publications	Number of Patients	Significant Improvement†
Contact Dermatitis	27	750	713
Eczematous Dermatitis	21	472	409
Seborrheic Dermatitis	18	442	426
Atopic Dermatitis	24	460	426
Psoriasis	36	1,699	1,510
Neurodermatitis	18	351	324
Total	144	4,174	3,808

*Complete bibliography on request.

†Expressed by the authors as excellent, very good, good, complete remission of inflammation, etc.

PRESCRIBING INFORMATION

For initiation of therapy: Cream 0.025%, 5 and 15 Gm. tubes, 425 Gm. jars; *for emollient effect:* Ointment 0.025%, 15 Gm. tubes; *for maintenance therapy:* Cream 0.01%, 15 and 45 Gm. tubes, 120 Gm. jars; *for intertriginous or hairy sites:* Solution 0.01%, 20 cc. and 60 cc. plastic squeeze bottles; *for infected inflammatory dermatoses:* Neo-Synalar® Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes.

CONTRAINDICATIONS: Tuberculous, fungal, and most viral lesions of the skin, (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. PRECAUTIONS: Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. When severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. SIDE EFFECTS: Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. The neomycin in Neo-Synalar Cream rarely produces allergic reactions.

REFERENCES: 1. Lerner, L. J., Bianchi, A., Turkheimer, A. R., Singer, F. M., and Borman, A.: Anti-inflammatory steroids: potency, duration and modification of activities. Ann NY Acad Sci 116:1071 (Aug. 27) 1964. 2. Idem: Comparison of anti-granuloma, thymolytic and glucocorticoid activities of anti-inflammatory steroids. Proc Soc Exp Biol Med 116:385 (June) 1964. 3. Ringler, A.: Activities of adrenocorticosteroids in experimental animals and man, in Dorfman, R. I.: Methods of hormone research, New York, Academic Press, 1964. vol. III. pp. 234-280. 4. Gubersky, V. R.: To be published.

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Most of these are probably among patients over 40; the overweight; relatives of diabetics, and mothers of large babies. By the time polyphagia, polyuria, polydipsia, pruritus or other overt symptoms of diabetes appear, damage may have been done that could have been minimized. DEXTROSTIX® gives you a reliable blood-glucose estimate in 60 seconds.

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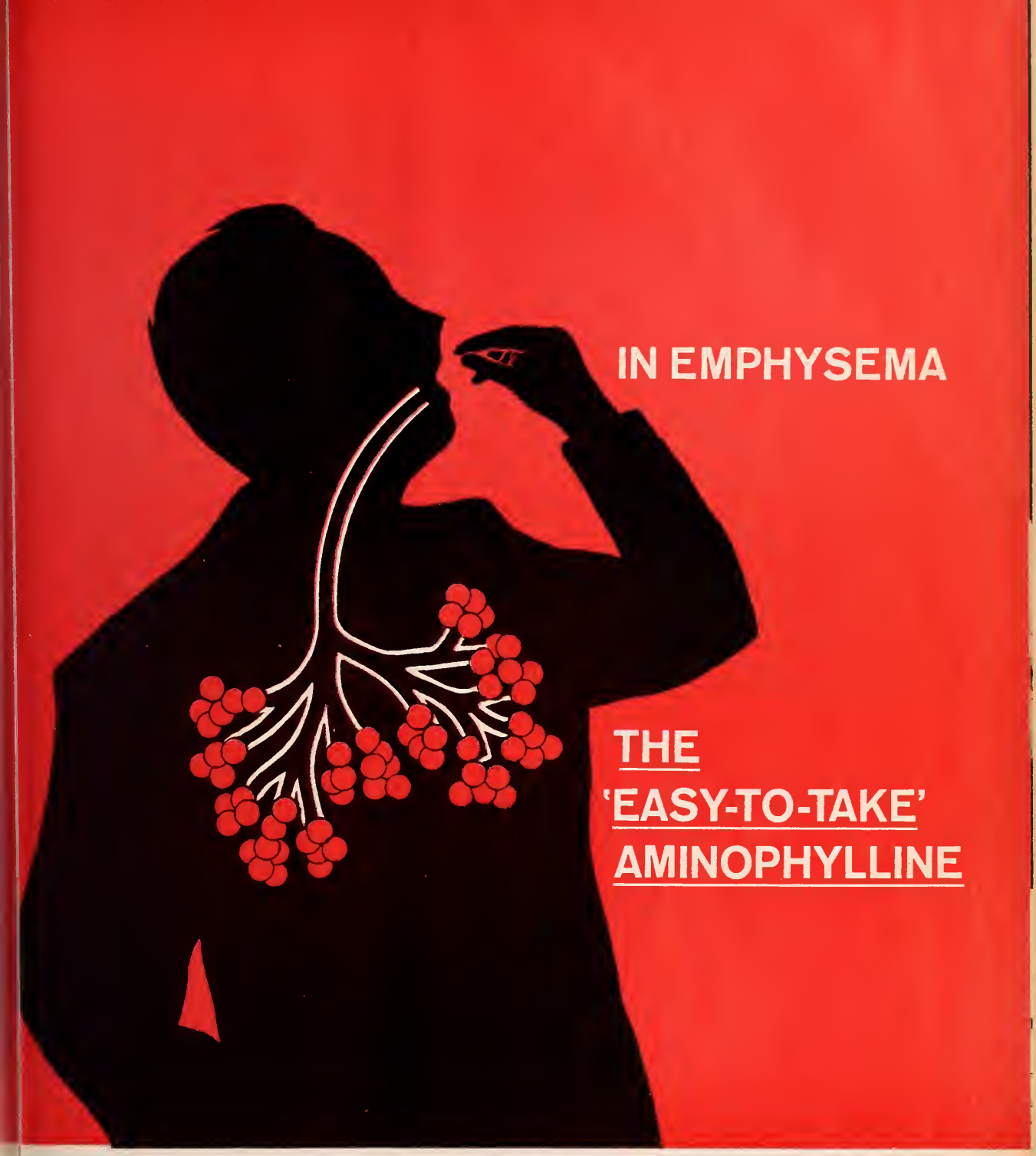


*Based on Statistical Report, U.S. Dept. Commerce, ed. 86, and Fisher, G. F., and Vavra, H. M.: Pub. Health Rep. 80:961 (Nov.) 1965.

Note: DEXTROSTIX is not meant to replace the more precise analytical laboratory procedures such as needed in glucose tolerance testing.

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Ames



Aminophylline dura-tabs®

prolonged-medication tablets 4½ gr. (0.3 Gm.)

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Dosage: Adults, 1 to 2 Aminophylline Dura-Tabs each 8 or 12 hours, with food.

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Oral aminophylline needn't disturb the stomach—nor a good night's sleep. Patients breathe easier all day, sleep better all night, as each Aminophylline Dura-Tab dose provides effective therapeutic activity for up to 12 hours. And unlike conventional tablets, AMINOPHYLLINE DURA-TABS seldom cause gastric distress. The special Dura-Tab process allows the gradual absorption of the medication from the intestinal tract with only a small fraction of the dose released in the stomach.



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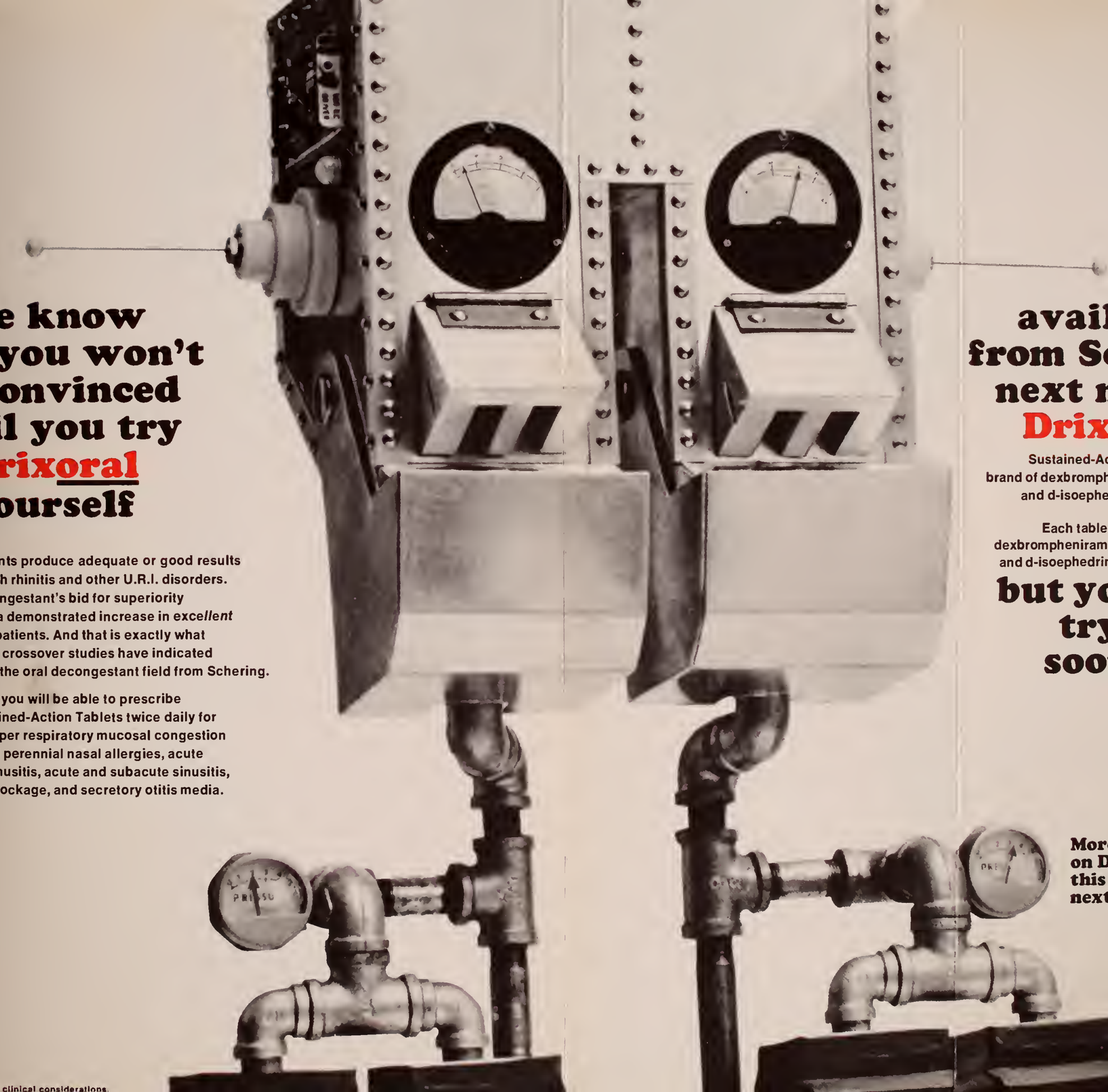
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available from Schering next month Drixoral™

Sustained-Action Tablets
brand of dexbrompheniramine maleate and d-isoephedrine sulfate

Each tablet contains dexbrompheniramine maleate 6 mg., and d-isoephedrine sulfate 120 mg.

but you can try it sooner

More details on Drixoral and this mechanical man next month.

See last page of advertisement for clinical considerations.

Schering introduces Drixoral™



Double-blind and crossover studies[1-3] show superior results with an oral decongestant, but...

Saa last page of advartisament for clinical considarations.

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Sustained-Action Tablets
brand of dexbrompheniramine maleate and d-isoephedrine sulfate

Each tablet contains dexbrompheniramine maleate 6 mg., and d-isoephedrine sulfate 120 mg.

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Rafarancaa:
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2. Frank, D. I.: Curr. Tharap. Res. 6:158, 1964.
3. Fierbarg, A. A.: Ann. Allergy 22:324, 1964.

S-281



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brand of **nitroglycerin** 2.5 mg. in micro-dialysis cells

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"You're up ten pounds since your last physical. We're going to have to do something about that."

Get them while they're easily reversible.

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Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.
Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.
Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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Sustained Release Capsules

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The fast-disintegrating uncoated tablet gives relief in 15 minutes

Each tablet contains:

Potassium Iodide	195 mg.
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Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

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Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

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oxyphenbutazone

Tandearil in Painful Shoulder

Therapeutic Effects: Stiffness and pain may diminish within 2 days, and full mobility may be restored within a week. These effects are obtained with oxyphenbutazone alone or combined with physiotherapy or local hormonal injections. The drug is usually well tolerated and does not affect pituitary-adrenal function or immune response.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Painful Shoulder: 600 mg. daily in divided doses for 2 to 3 days; 300 mg. daily thereafter. Usual duration of therapy: 2 to 7 days.

Availability: Tablets of 100 mg. 6562-VI(B)R

For complete details, please refer to full prescribing information.

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Tandearil® oxyphenbutazone helps painful shoulders move again



3 out of 4 painful shoulder patients responded well

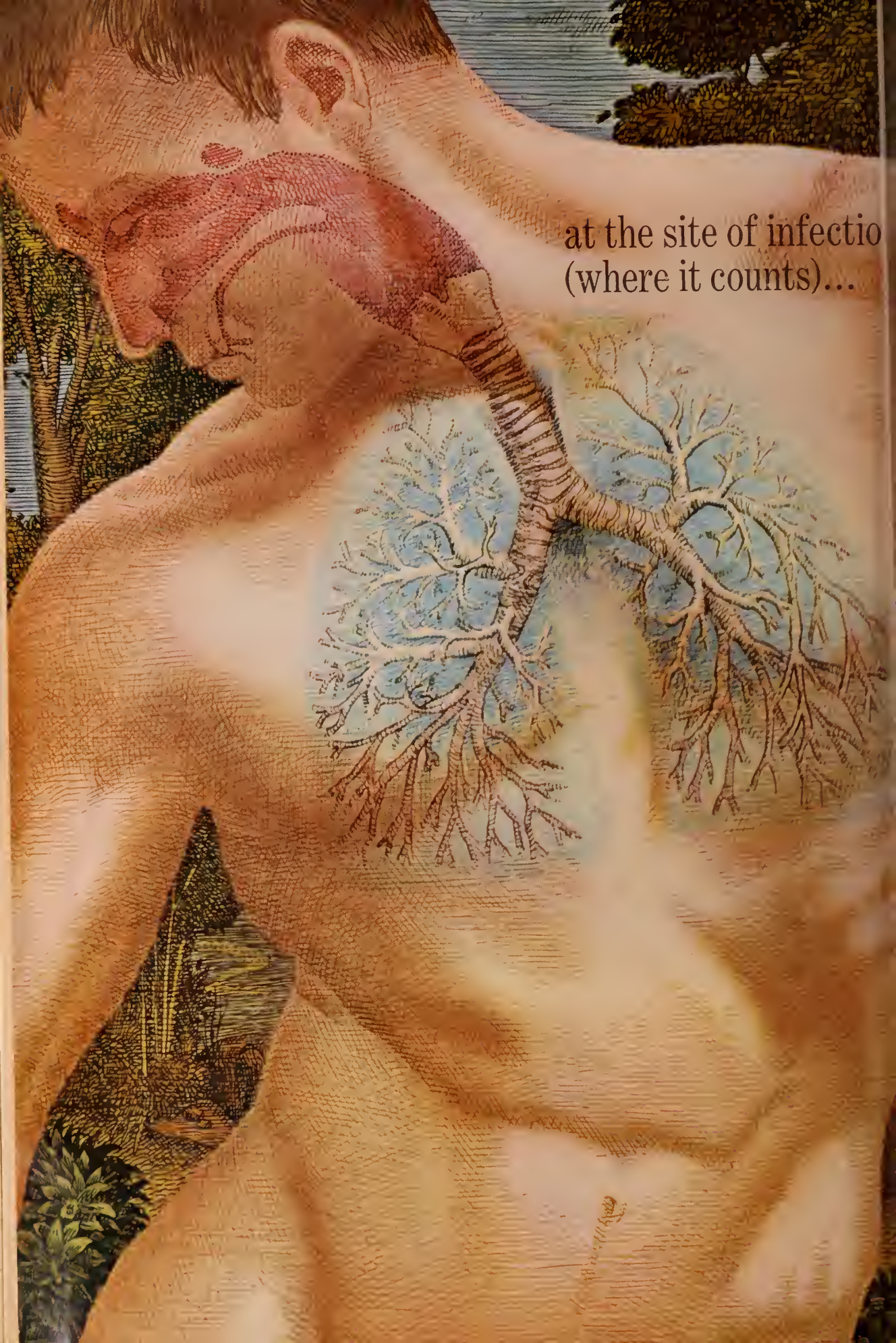
84.2% of 127 patients

81% of 48 patients

Please see adjoining page for brief prescribing summary.

TA-5094PC

Sperling, I L
Applied Therap. 6 117, 1964
Rosenbaum, E. E., and Schwarz, G. R. Northwest Med. 61 927, 1962


at the site of infectio
(where it counts)...

Ilosone® provides more antibacterial activity than any other oral erythromycin

Acid stable, better absorbed... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food[1-3]

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

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New! Ready-mixed Ilosone Liquid 125! (Contains erythromycin estolate equivalent to 125 mg. erythromycin base per 5-cc. teaspoonful.)

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Erythromycin Estolate

(See next page for prescribing information.)

Ilosone®/the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have also been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Adverse Reactions: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have developed in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly, usually within forty-eight hours, if the drug is readministered to sensitive patients. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice ap be definitely related to use of the drug, laboratory findi characterized by increased direct-reacting bilirubin, alkaline phosphatase levels, negative or weakly positive flocculation and thymol turbidity tests, elevated serum oxalacetic transaminase levels, peripheral eosinophilia, mal cholecystograms.

Individual idiosyncrasy seems evident since jaundic been reported in other patients taking prolonged cours medication. Patients with chronic infection have been g to 2 Gm. of the drug daily for periods of two to six mo patients with rheumatic fever have taken prophylactic 0.5 Gm. daily for two years without difficulty. In one 144 patients who received the drug daily for two years, dice was noted. It was of interest that members of six patients' families, who were not taking the drug, had of jaundice during the study period.

Transaminase and serum alkaline phosphatase lev determined in a group of fifty-four adults and children 250 mg. of Ilosone daily for an average of sixteen m rheumatic fever prophylaxis. The results were compa those of a similar group of forty-four patients who rece icillin. There were no cases of jaundice in either group. I of SGPT and serum alkaline phosphatase levels during t of treatment was observed in one patient treated wit and in two patients treated with penicillin. Seven other in the group receiving Ilosone and four others in the group showed elevations in one of the tests at some tim administration of the drugs.

Very satisfactory therapeutic results, without toxic reported in 102 pediatric patients who received short-te day) courses of Ilosone in the treatment of streptococc tions. Results of liver function tests in these patie comparable to those in a similar control group who had penicillin.

Gastro-intestinal disturbances not associated with h fects are observed in a small proportion of individuals a of a local stimulating effect of the medication on the al tract; however, the normal intestinal gram-negative flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon wit of erythromycin, there have been occasional reports of skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered or Ilosone Pulvules®, Ilosone Liquid 125, Ilosone, 125, Suspension, Ilosone Drops, Ilosone Chewable Tablets.

For infants and for children under twenty-five pound weight, the usual dosage is 5 mg. per pound every six h children twenty-five to fifty pounds, 125 mg. every s (Tablets Ilosone Chewable should be chewed or cru swallowed with water.)

For adults and for children over fifty pounds, the usu of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled

When larger doses are indicated, parenteral eryt therapy should be considered.

In the treatment of syphilis, the recommended total 20 to 30 Gm. given in divided doses for a period of ten days. Close follow-up of the patient is necessary since mycin drugs have not had adequate evaluation in all syphilis. Examinations of spinal fluid are recommende of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four recommended. In the treatment of gonorrhea, patient suspected lesion of syphilis should have a dark-field exa before receiving antibiotics, and monthly serologic tes be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 an (equivalent to base), in bottles of 24 and 100.

Ilosone Liquid 125, Oral Suspension, U.S.P., 125 mg. (e to base) per 5-cc. teaspoonful, in 60-cc. and pint-size

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (e to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 1 packages, with dropper calibrated at 25 and 50 mg.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent in bottles of 50.

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., 2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., 3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 1960.

Additional information available to physicians upon request.

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If his emotional symptoms persist in the face of your counsel and reassurance, you may want to consider adjunctive use of SERAX (oxazepam). It is indicated in anxiety, tension, agitation, irritability, and anxiety associated with depression. May be used in a broad range of patients, usually with considerable dosage flexibility.

When prescribing, carefully observe dosage recommendations and appropriate precautions, especially as pertaining to the elderly and when complications could ensue from a fall in blood pressure. (See Wyeth literature or PDR as well as "IN BRIEF" below.)

IN BRIEF.

Contraindications: History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. Withdrawal symptoms upon discontinuation have been noted in some patients exhibiting drug dependence through chronic overdose. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose; excessive, prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Withdrawal symptoms following abrupt discontinuance are similar to those seen with barbiturates. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance. Safety for use in pregnancy has not been established.

Not indicated in children under 6 years; absolute dosage for 6- to 12-year-olds not established.

Side Effects: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leucopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age. These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever and euphoria.

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EDITORIALS

The New Drug Control Bill

A bill of daily concern to all medical practitioners is S.1303 introduced by Senator Long and Senator Morse on March 15, 1967. The following analysis of the bill was made by the Pharmaceutical Manufacturers' Association. S.1303 is an omnibus bill which is entitled "The Quality and Cost Control Standards for Drugs" Act. It proposes a number of amendments to the Social Security Act and to the Federal Food, Drug, and Cosmetic Act. It proposes to establish a nine-member Formulary Committee consisting of the Commissioner of the Food and Drug Administration, the Surgeon General of the U.S. Public Health Service, the Director of the National Institutes of Health, the Commissioner of Narcotics and five individuals of "recognized professional standing" in medicine and pharmacy. It mandates the development and publication of an official Formulary of the United States. The Formulary would be distributed to physicians, dentists, pharmacists, hospitals, and "other health-care institutions," interested public and private agencies, and "appropriate individuals." It would consist of two sections:

The first would list drugs and biologicals included (or approved for inclusion) in the U.S. Pharmacopeia, the National Formulary, the U.S. Homeopathic Pharmacopeia, New Drugs, or Accepted Dental Remedies. It would add drugs and biologicals which the Formulary Committee "determines to be necessary or proper for such purposes."

The Formulary Committee *may* include trade name drugs or combination products if they (1) have *distinct, demonstrated therapeutic characteristics* not otherwise available, (2) are available at a *lower cost* than like products available by established name, or (3) are generally available and sold only under trade names and are the only products of a quality *acceptable to the Formulary Committee*. This Committee is told to exclude from the Formulary (1) any drug or biological which it determines to be "unnecessary or therapeutically duplicative" or (2) any drug product which the Formulary Committee determines to be of "unacceptable quality."

A second section would list, either individually or by class or type of the drugs, biologicals and drug products *excluded* from the Formulary.

The formulary would list drugs and biologicals by their established (generic) name.

The Formulary Committee is authorized to obtain any record (confidential or otherwise) pertaining to the characteristics of a drug, available to any agency or department of the Federal Government, in making a determination whether a particular drug should be included in the Formulary. The Committee may make tests and establish procedures necessary to determine the inclusion or exclusion of any drug in the Formulary. The Formulary Committee may contract with public or private agencies to conduct necessary tests. Prior to making a final determination to exclude a drug from the Formulary, the committee is required to afford opportunity for a hearing to any person manufacturing or processing the product. Any person adversely affected by such a determination may appeal to Court.

The term "qualified drug" is defined as a *drug* or *biological*:

(a) Listed in the Formulary, or

(b) Furnished "to a patient by a hospital" accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association which utilizes a formulary system established in accordance with standards of the Accreditation Commission or AOA.

(c) In either situation the drug or biological must also:

(1) Be prescribed or furnished under conditions and according to requirements to be established by the Formulary Committee designed to "assure the orderly, efficient, and proper usage of drugs and biologicals," and

(2) Have on the label on the package or container the registration number of the person or establishment which manufactured, prepared, propagated, compounded, or processed the drug.

"Reasonable Cost" — The Secretary of HEW is told to establish and revise periodically a guide showing the "reasonable cost range" of each qualified drug listed in the U.S. Formulary. In establishing the "reasonable cost range, the Secretary must *not* take into account the price of any drug which does not have on the label of the package or container the registration number of the person or establishment which manufactured, compounded, or processed the drug.

The "reasonable cost range" of any particular drug, the bill says, must not exceed the price at which the drug is "generally available for sale by its established name, or by trade name, *if lower*. Prices charged by suppliers which "vary excessively" must be excluded by the

Secretary in determining the cost range. The "range" could be the price at which a trade name drug is generally available if it is (1) available from more than one supplier, (2) available by established name and by trade name, and (3) as available by trade name it "possesses distinct therapeutic advantages" as determined by the Formulary Committee of the Government. The price may be adjusted by the Secretary whenever he determines that, in a particular area, the price varies substantially from the price at which the drug is available in other areas.

The price at which a drug is "generally available" in cases when the dispenser sells to the ultimate consumer is the "actual or accounting basis cost" of the drug to such dispenser plus a reasonable professional fee (which shall include "costs of overhead and costs of providing professional services") for dispensing such drug.

In connection with the "reasonable professional fee" the Secretary is instructed to establish criteria for determining the amount of the fee after consulting with organizations and agencies concerned. The Department may make agreements with any state having a *public agency* charged with the duty of establishing reasonable professional fees for the dispensing of drugs to determine and establish reasonable professional fees for the purpose of this Act.

Effective July 1, 1969, there will be an additional requirement for approval by a state plan, giving a beneficiary under a Title XIX program the right to obtain prescription drugs from any community pharmacist in accordance with "reasonable cost and service requirements" established under the state plan.

The Young Driver

The record of young drivers worsened in 1966, according to The Travelers Insurance Companies. Drivers under 25 were involved in almost 32 per cent of the fatal accidents compared with 30 per cent the previous year.

This commentary is contained in The Travelers annual highway safety booklet, which reports 52,500 deaths and more than 4,400,000 injuries on America's highways last year. Statistics in the booklet were compiled from reports by state motor vehicle departments. The Bureau of Public Roads has reported that drivers under 25 constitute about 19 per cent of all licensed drivers — but in 1966 they were involved in almost 70 per cent more accidents than their numbers warrant. Older drivers, those 65 and over, showed a slight improvement in their driving records as did the largest group of licensed drivers — those 25 to 64. However, drivers over 65 continue to be involved in proportionally more fatal accidents than non-fatal accidents. "Perhaps," says a Travelers spokesman, "it can be accounted for by saying that the young are quick and impatient and the old are stubborn."

The National Traffic Safety Agency has issued some vehicle safety standards. Some of the new features are included in or can be added to present cars. All of them are an important part of the nation's intensified efforts to reduce the traffic accident toll. Research is also essential. At a Traffic Safety Conference in Hartford, Connecticut early this year there was wide agreement between auto insurance industry leaders and traffic safety research scientists that we need to learn more about how the various elements in the auto transportation system — the road, car, driver, laws, etc. — contribute to accident prevention.

Parents of newly-licensed drivers should insist that the youngster drive a car that's mechanically sound. He should be solo-driving, or driving with his parents, not with a car-full of chums. He should be driving on little traveled roads. And, he should be driving in daylight, only in fair weather at first. Gradually, as handling a car begins to feel natural to him, he should—under supervision — begin driving under a variety of situations until all concerned have confidence that the young driver knows what he is doing, and why he is doing it.

The brochure, "Was it Sudden?", is a sprightly and crystal-clear summary of automobile accident data in 1966. Copies are available from the Travelers Insurance Companies in Hartford.

ORIGINAL ARTICLES

In this view, the concept of "overall health planning" is given some specific meaning.

The Present Health System Defined*

Anne R. Somers/Princeton

I don't know whether the Planning Committee intended this title as a challenge to the ingenuity of the speaker or the credulity of the audience. My dictionary defines "system" as "an organic or organized whole, as the solar system." By this definition there is no health system in the U.S.A. today. Having said this, perhaps I should now sit down, having made the briefest and most succinct speech in the annals of medical care.

I don't intend to let you off so easily, however. Even if there isn't anything that can be called a "health system," there most certainly is a booming health services' industry, the third largest in the country, employing over three million persons, with transactions in the order of $50 billion this year; that is about $137 million every day. System or nonsystem, health care is obviously very big business.

How does one describe, let alone define, this huge, sprawling, important segment of the American economy and American life, in terms that are meaningful for planning? As some of you know, my husband and I tried to do this several years ago in a book entitled *The Organization and Financing of Medical Care*. But it took us nearly four years and 576 pages. I doubt if you have this much patience today!

To cope with this dilemma I have decided, first, to limit myself to one community—Trenton, New Jersey—and use it to illustrate the present nonsystem. Like many other urban communities, Trenton is both a city and the center of a standard metropolitan statistical area—Mercer County. Also, typically, the city is losing population while the suburban area is gaining rapidly. The city is now estimated at 109,000; the county at 290,000. The city is about twenty-eight per cent Negro, three per cent Puerto Rican.

Trenton is not a statistically perfect representative of Middletown, U.S.A. But it does contain, in microcosm, most of the major problems facing health planners today. Conditions in New Jersey are certainly no worse than elsewhere; probably better than average. Let me concentrate on two areas where the present nonsystem is particularly conspicuous: the general hospital — heart of the voluntary health establishment, and the public assistance medical programs—a major challenge to the public sector.

The Health Status of the City of Trenton

By all the common indicators—mortality rates and incidence of reportable diseases — Trenton's record is bad. Its death rate in 1964 was 13.2 per 1000 population compared to 9.7 for the state as a whole and 9.4 for the nation. Infant mortality rate was 36 per 1000 live births compared to 24 for the state and 25 for the nation. The 1964 rate represents a rise of 35 per cent over 1960. New Jersey law prohibits racial distinctions in vital statistics but it can be safely assumed that the Negro rate is vastly higher than the white.

Trenton's tuberculosis and venereal disease rates are three times those for the state as a

* Delivered by invitation at the National Health Forum, "Planning for Health," Chicago, March 20, 1967. Mrs. Somers is a Research Associate in Industrial Relations, Princeton University.

whole. Perhaps more surprising, its death rates from virtually all the major causes — cancer, heart disease, accidents, and so on — are far above state and national levels. While there are no comparable statistics for alcoholism, drug addiction, and mental illness they are known to be high. In 1964, some 14 per cent of all babies born in Trenton were born out of wedlock; in the state 6 per cent. Most of the communicable diseases are concentrated in the same 20 per cent of the families that constitute the city's multiple-problem poor. United Progress Inc., Trenton's lively anti-poverty agency, has documented case histories of families, well known to welfare and law enforcement agencies, with syphilis, tuberculosis, alcoholism, and heroin addiction, all present.

It would be a mistake, however, to conclude that this tragic condition is typical of all Trenton. On the contrary, probably well over half the population enjoys good health and another 25 per cent, while suffering various chronic ailments, are able to function with reasonable satisfaction. Even among the upper and middle-income groups, however, there is more serious illness than appears on the surface. I spent several hours recently with a group of young mothers at the YWCA, chosen at random from among those waiting while their children took a swimming lesson. Over 60 percent stated that they had no serious illness or health problem in their families. But the others did have problems: the husband of one had serious hypertension. Another had been exposed to German measles while pregnant and her baby had a cataract. A third woman had a serious pituitary problem.

In our concern to tackle the appalling health problems of the poor and the minority in all income groups who suffer serious illness, it is important to keep a sense of perspective. All America is not sick. On the contrary rising health standards are as much a part of our revolution of rising expectations as rising income and educational levels and inextricably related thereto. A portion of current ill health is related to inadequate medical care, and this is not confined to the poor. But the major health problems are part of the larger problems of poverty, racial discrimination, lack of education, and general alienation of a considerable segment of society.

Trenton's Hospitals: The Challenge to Voluntarism

The city has three general short-term hospitals, ranging from about 250 to 500 beds and one 40-bed institution — all accredited. The total rated capacity, according to U.S.P.H.S. standards is about 1050 although the number in actual use is about 100 more. Some 40 are psychiatric. The only other general hospital in the area is in Princeton which is currently expanding to nearly 200.

There is wide and passionate difference of opinion as to whether the current number of beds is adequate. The issue has been precipitated by the proposal of the 40-bed hospital to move into one of the growing suburbs and build a 200-bed institution. Arguments pro and con relate not only to the overall adequacy of the present number of beds, but to the uneven occupancy of the different services, to the problems of physicians who are not on the staffs of the three major hospitals, and to the acute manpower shortages affecting hospital staffing.

The ratio of beds per 1000 population for the county (any such figure for the city is meaningless since the hospitals serve a much larger area) is 3.6 or 4.0, depending on which bed count one uses. The national average is 3.9. Average occupancy of the four hospitals during the past year was 76 or 86 per cent, again depending on which bed count is used. At the moment, the peak season, it is close to 100 per cent in most medical-surgical departments. On the other hand, the maternity service in one hospital averaged only 38 per cent last year and the highest was 72. Pediatrics was only 65 per cent in two hospitals.

Medicare has complicated the problem of evaluating adequacy. There has been great uncertainty as to the program's long-range impact. In the largest hospital, the ratio of Medicare patient-days to all patient-days rose from 24 per cent in August 1966 to 30 per cent

in December and has since leveled off at 28 in February. In the second largest hospital, this same index rose from 22 per cent in the first six months of 1966 to 25 in the first six months of Medicare to 26 in January. Thus, at the moment, both appear to be stabilizing within the Social Security Administration's 30 per cent projection. The one disturbing Medicare statistic in all hospitals relates to length-of-stay. Average stay for the elderly rose from about 14.5 days in the early days of Medicare to 16 or a little more in mid-winter.

The causes for this rise are still not clear but are obviously important for future hospital planning. There is difference of opinion as to the effectiveness of the utilization committees. Most observers feel that they are working conscientiously, better than expected. But there are really no adequate "extended care facilities" to which Medicare patients can be moved for post-hospital convalescence. There is not a single certified such facility in the city of Trenton although there are three in the area and several just across the Delaware River in Pennsylvania with which Trenton hospitals have transfer agreements.

The waiting list for "extended care" admissions is not as great as this situation might suggest but this may reflect simply an acceptance of the situation as hopeless, and some physicians have not yet learned to use "extended care facilities" as fully as anticipated. The demand for those beds is almost sure to grow as their supply and experience with their use increases.

A third cause may be failure to utilize home health services fully. Thanks partly to Blue Cross experimentation in this area, Trenton's major hospitals have been interested in home care for some time and wished to set up a coordinated service utilizing the local Visiting Nurse Association. The latter proved inadequate to the challenge, however. To meet Medicare standards, changes in the Association's leadership and staffing have recently taken place and it is now hoped that closer cooperation between it and the hospitals will result. In some quarters, however, it is felt that the full potential of home health services can not be realized unless the professional nursing services are supplemented by homemaker services.

The three major hospitals all operate 24-hour emergency rooms, and all have a full range of specialty clinics—from allergy to urology—for the indigent. All provide diagnostic and other services to private ambulatory patients. The demand for these services is growing. In the largest hospital, for example, total ambulatory services rose 24 per cent in the year 1965-1966. Almost 40 per cent of the 1966 total were rendered in the emergency room. In another hospital, emergency room visits doubled between 1956 and 1966.

In the face of this avalanche of demand, traditional hospital programing, staffing, and financing arrangements are breaking down. The situation with respect to private services is easier to cope with although it remains unsatisfactory in many respects. The impact of Medicare (with its mandatory bifurcation of hospital from professional services and diagnostic from therapeutic services) has exacerbated a pre-existing situation. Costs to both hospitals and patients are skyrocketing. But by and large good service is being provided. But in the Emergency Room, the problem is more acute. Aside from the sheer volume of demand, several factors have combined to make obsolete its traditional pattern of staffing — primarily by nurses and interns with back-up services by on-call surgeons. Among these new factors are the growing number of non-emergency, non-surgical cases, the large number of paying patients who demand faster and better service than the indigent, and the fact that in Trenton (as in New Jersey generally) most interns and residents are of foreign birth and many of them have trouble communicating in English.

The largest hospital changed its Emergency Room staffing last summer. Eighteen senior physicians have organized themselves into a formal group — the first in Trenton. They have contracted with the hospital to provide 24-hour service. All maintain their regular

private practices and rotate the Emergency Room work. The majority are surgeons but the group includes an obstetrician and several general practitioners. They are not paid by the hospital. The minimum charge to patients is $12.50, of which $7.50—actual cost—goes to the hospital, $5 to the physician. For those with Blue Cross and Blue Shield or other applicable insurance, the situation is relatively painless financially. For the uninsured, the cost is high and the collection ratio last year was only 66 per cent. There is no payment for welfare patients. The hospital is generally pleased with the experiment. Quality of care is reported to be improved. Still there remains the unsolved problem of "no collections" for a third of the services and admittedly burdensome charges to uninsured patients who do pay. Despite these drawbacks it is such an improvement over the previous situation that a second hospital is trying to work out a similar arrangement with its staff.

In two of the three major hospitals the indigent clinics are staffed mainly by unpaid "attendings," typically for 2 to 3 hours a week for one month in four. Ward service is generally preferred to clinic work and the latter devolves on the younger and less prestigious members of the staff. Their resentment is understandably passed along to nurses and patients alike. In one hospital, the clinics are staffed mainly by the 23 residents.

Virtually nobody pays for these services. Some hospitals have a nominal 50-cent charge. Welfare Departments pay nothing. Not only is there no Blue Cross or Blue Shield coverage but Blue Cross (since it covers only inpatient care) deducts from its hospital reimbursement payments the costs of any outpatient services which the hospitals may provide. This is fair to inpatients and to Blue Cross subscribers generally, who can obtain only coverage of inpatient care. But it is a constant irritation to the hospitals who see in every clinic patient an additional deduction from their Blue Cross reimbursement.

Medicare will pay for its patients—provided they meet the deductible, which may be $20 or $50 depending on the type of service rendered, and provided the hospital knows its costs and can bill the program accordingly. Considering the present state of hospital accounting and the state of finances of most clinic users, these are two formidable obstacles.

The whole situation with respect to the clinics is unsatisfactory—to the hospitals, doctors, patients, and the community. Some observers say the services are good, almost certainly better than the same patients would be receiving from non-hospital physicians on the outside. Records are generally kept. Inpatient admissions are made as needed. On the other hand, continuity of care is almost impossible although this situation is said to be better in the hospital staffed by residents than by "attendings." Unfortunately, communication with the foreign-born residents is often difficult.

Impersonality, long waits, restricted hours†, the difficulty of making appointments, and lack of consideration for the patient as a person are almost universal complaints. This has a negative effect both on the success of the treatment and the patient's general attitude toward health and medical care.

The situation in the hospital staffed by residents is probably the best. Their clinics are more closely coordinated with other ambulatory services, sharing the same supervisor, social service office, and some of the same space. If problems of staffing and financing could be solved, this institution could probably move, without too much difficulty, to a single comprehensive ambulatory service, providing both regular and emergency care to a large cross-section of the population. A good Title XIX state program could conceivably provide the breakthrough with respect to financing. There is no sign of a breakthrough with respect to staffing unless it is the continued use of residents. If this is to be the pattern of the future, however, it is diametrically opposed to the

† There are no night clinics, most clinics meet once a week only, and some are held as infrequently as once a month.

direction advocated in the Millis Report,** and will certainly require some serious thinking-through by academic medicine, the practicing profession, and the hospitals.

The Challenge to The Public Sector

There is no "Medicaid" (Title XIX) program in New Jersey as yet. Aside from those who are now under Medicare, the state's welfare recipients depend for their medical care on the categorical assistance programs operated by the 21 counties and those of the 567 municipalities that choose to operate general assistance programs. The net result is a mish-mash of widely varying programs, with large gaps in both services and coverage, some overlaps, no quality controls, and costing $32 million last year. About half of this went to nursing homes.

The principal gap in service is hospital care. Until 1962, the state had no vendor payments of any kind. They were started in that year but only for physicians' services. Freeholders in the various counties and some of the larger municipalities continued to make lump sum payments to selected hospitals for care of the indigent but generally without any relation to services rendered or to costs. In 1963, MAA —medical assistance for the aged—was started and a new hospitalization program devised for old age assistance recipients. For the latter, the state began to purchase Blue Cross coverage. Under MAA, hospitals were paid full costs based on the Blue Cross formula, with Blue Cross acting as fiscal intermediary. But after July 1966, when Medicare took over hospitalization of the aged, the state reduced its hospitalization program for both MAA and OAA patients to payment of the deductible and coinsurance. It has continued to use Blue Cross for this purpose, at a fee of $2.25 per claim. It has bought into Medicare Part B for OAA recipients and worked out an arrangement with physicians who are willing to accept Medicare assignment for MAA patients to pay 80 percent of their deductible. The Prudential Insurance Co. (Part B carrier for New Jersey) is also the state's fiscal intermediary for this program at a cost of 87 cents per claim.

Recipients of the three other categorical assistance programs — Assistance to the Blind, Disability Assistance, and Assistance for Dependent Children—have no hospital benefits. The county payments to hospitals are intended to help cover the cost of inpatient care rendered to these groups but, in fact, generally cover less than half; in Mercer County—42 per cent. No payment is made for outpatient services. Until recently, the lump sums were completely arbitrary. In Mercer, however, they are now prorated, by the Health Facilities Planning Council, on the basis of patient days.

General assistance is administered by the municipalities. Those that are willing to accept certain minimum standards do receive state aid. Trenton, one of the state-aided cities, allocated $60,000 to its hospitals on behalf of city relief clients in 1966.

Physicians' services and drugs are also provided to persons on categorical assistance. State policy, which is nonmandatory on the counties, has just increased payments to physicians to $5 for an office call, $6 for a home visit. Every effort is made, however, to encourage clients to use the free hospital clinics instead of outside doctors. Prescription drugs are provided, within specified limits, at wholesale cost plus $1.50 professional service charge for each prescription. There is no formulary and no requirement for generic prescribing. Non-prescription drugs are paid for at the usual charge.

(If you are beginning to feel somewhat confused, perhaps even a little irritated by all this detail, this is not entirely accidental. May I suggest that you put yourself in the position of the social worker who has to explain these programs to her client — or better still the client himself whose life may depend on his ability to find his way through this maze.)

Some indication of the adequacy of these programs is provided by recent cost statistics. In December 1966, the average *per capita* cost of

** AMA Council On Medical Education, *The Graduate Education of Physicians,* Report of the Citizens Commission On Graduate Medical Education, John S. Millis, Chairman, 1966

vendor payments on the ADC†† program in Mercer County, for example, was $1.36; for the average institutionalized recipient of disability assistance, $92.81. The shortcomings of the present relief medical programs are overwhelming and apparent. The inconsistency between programs is matched by that between localities. A pharmacist gets more for a 5-minute job of transferring pills from a big container to a small one than the average child on ADC gets for a month's medical care. Hospitals are underpaid or not paid at all. There is no quality check on the medical care rendered in nursing homes and part of the expenditure for this purpose is thought to be wasted.

Waste is also built into the method of providing physicians' services. In some cases, public health nurses could serve as well but are not available. In others, a county welfare doctor and a city welfare doctor visit the same family on the same day. Each may refuse to look at any member of the family except the particular client. State officials say that the absence of a drug formulary has not affected costs. This is difficult to believe. In any case, it deprives the public of one method of controlling quality. But then quality controls are absent from the entire program.

Fortunately, Title XIX offers a potential instrument for the long-overdue overhaul of the state's welfare medical programs. Much soul-searching is currently in progress, especially within the Department of Institutions and Agencies — our welfare department. The cost will be high, however. Assuming a comprehensive program, and eligibility up to $4000 for a family of four — approximately 20 per cent of the population — the total cost is estimated at around $240 million of which the non-federal share would be in the order of $114 million. Certainly, anything approaching a comprehensive Medicaid program will require a state income tax. To this formidable hurdle must be added the additional obstacles that will inevitably beset adoption of such a program with respect to professional fees, quality controls, and so forth.

†† The "Aid to Dependent Children" program.

Where Do We Stand Today?

There are obviously dozens of other important aspects of Trenton's health care problems that would have to be studied for a complete survey. Even this limited exploration, however, is enough to provide considerable insight into the major strengths and weaknesses in the care available to the community. Viewed in the context of other programs and services, it is possible to arrive at some sort of balance sheet, and to suggest directions in which reforms are most urgently needed. This brief evaluation is presented under five headings: public concern for health, quantitative adequacy of health resources, quality of care, adequacy of financing, and mechanisms for coordination or planning.

Public Concern

Whether one thinks in terms of individual and family concern for their own health, and willingness to assume responsibility therefore, or in terms of organized community activity, the people of Trenton are highly health-conscious. This is most apparent in the upper and middle-income levels of the population. Among the group of mothers interviewed at the YMCA for example, all agreed that the family had primary responsibility for the children's health. All were prepared to spend a good deal of money on preventive services. One woman, who had just completed her family's income tax, said, without any bitterness, that they had spent $766 — a fairly sizable chunk of their total income (her husband is a school teacher) on "health" last year, without any real illness. About $250 of this went for Blue Cross and Blue Shield. This family is also discriminating in its choice of care. The adults go to a medical group in Princeton, but they use a pediatrician in Trenton.

Another indication of health consciousness—often ignored or disparaged—is the amount of "do-it-yourself" health activity that goes on outside the recognized medical care establishment. One evidence is the popularity of question and answer health columns in the local papers. Another is the thriving business done by the local health food store. Whatever the

Food and Drug Administration or some doctors may feel about the efficacy of vitamins, yeast, wheat germ, and other food supplements, there is certainly a widespread yearning for health and many people's willingness to pay the price.

Trenton has fluoridation but it was only after a protracted battle. Popular response to oral poliomyelitis immunization has been notoriously inadequate. Smoking, overeating, and underexercising are as widespread in Trenton as in the nation generally. Most dramatic and serious of all is the apparent lack of concern for health among the underprivileged 20 per cent of the population. Hospitals and doctors, accused of lack of adequate concern for the poor and the inadequacy of the indigent clinics, can point to repeated cases of broken appointments, of disregarded medical advice, of drunkenness masked as illness, of failure to take children to the free well-baby clinics, of pregnant women who do not show up at the prenatal clinics until the third trimester — if then, and so on *ad infinitum*.

All of these charges are true but they are only half the truth. The other, and probably more basic, part of the story lies in the conditions under which these people live. How can one expect families with 8 or 10 children crowded into a couple of rooms, lacking all privacy, sanitary conditions, means of transportation to often far-off clinics, and any real hope for a better life, to feel any burning desire for a poliomyelitis pill or even to know what fluoridation is all about? Add to this negative socioeconomic background the negative experience that many of these people have had with medical care: the 6-month wait for an appointment at a specialty clinic, the 4-hour wait once they arrive, the impatience, brusqueness, and barely concealed contempt of some clinic doctors. These are more than enough to crystallize the negative, fatalistic, attitude of many low-income people toward all medical care.

Fortunately this is a distinctly minority attitude. Its presence will complicate and make more difficult all reforms. It will have to be understood and dealt with for what it is — a product of social and economic deprivation and alienation — and it will not be cured by improving the medical care system alone. Better housing, better education, improved racial relations — all of these are just as important, maybe more so. But recognition of the need for improvement of the total urban environment should not be used as an excuse for complacency or inaction on the part of those of us whose primary responsibilities lie in the health field.

In terms of organized activity, Trenton has an abundance of benevolent community organizations. The Directory of Community Services, published by the Social Service Council of Greater Trenton, includes 104 separate listings. More could have been added. A few of the largest are governmental but the great majority are voluntary. Almost half have some aspect of health as their primary concern. Many are doing outstanding work. No survey of Trenton's health activities would be complete without acknowledgement of this. Still one feels that the net result of this outpouring of community dollars and effort is somehow less than the sum of its parts. This reflects not lack of concern but lack of overall leadership that transcends the separate interests and, closely related, lack of effective mechanisms for translating concern into effective community action.

Quantitative Adequacy

In general, Trenton seems to have more than its share of basic health resources. The 500 members of the Mercer County Component Medical Society constitute a ratio of 172 per 100,000 population compared to a national average of 153. And there are, of course, local doctors who do not belong to the society.

There is dispute as to the adequacy of hospital beds. My own impression is that they are adequate overall but that real problems exist with respect to distribution as between different services and particularly with respect to admitting privileges for some doctors. It is not sufficiently recognized that, except in extreme emergency, a patient's access to a hospital bed depends on his doctor's access to that bed.

There is almost certainly a real and growing shortage of extended care facilities and nursing home beds. There is need for both: the post-hospital facility, equipped to provide professional nursing care, contemplated in the Medicare "ECF" concept, and a less professional, less expensive facility, prepared to give good domiciliary care to the aged and disabled.

Probably the greatest single gap in Trenton's medical services relates to primary family care for the poor. Many of the ingredients for such a service — not for the poor alone but for the entire community — exist in the present emergency rooms and hospital clinics. But a basic transformation in staffing, scheduling, financing, and above all, in attitude, would be required to meet the need.

United Progress is considering moving into this vacuum. It has just completed an extensive report advocating establishment of a $2 to $3 million dollar comprehensive neighborhood health center, affiliated with one of the hospitals, to serve some 23,000 Trentonians. Reaction to this proposal has been emphatic — and mixed. Regardless of the outcome, it has already served a useful purpose.

The need for additional specialized facilities is strongly felt by special groups. For example, rehabilitation people want another sheltered workship and a cardiac work evaluation center. Mental health authorities say there is a crying need for day-care centers for deprived children and for day-hospitals for adults. Some specialists deplore the lack of special units for open heart surgery or renal dialysis. Some of these claims are undoubtedly well founded; some the result of over-enthusiasm by their advocates. Here again the primary need is for a community-wide mechanism that can study each of these claims and many others and reach a decision that is in the interest of the entire community as well as the concerned professional personnel.

Quality of Care

Probably the greatest qualitative deficiency in the entire area is the lack of contact with a medical school. There are no schools in the area and none of the hospitals has an even distant medical school affiliation. The results are far-reaching. Virtually all interns and residents are foreign-trained. There is no medical research going on anywhere in Trenton except in the laboratories of the State Department and enquiry is missing. Full-time medical staffing — the now dominant pattern in most teaching hospitals — is unknown. Group practice, a logical result of academic specialization as well as full-time staffing, is almost totally absent.

Medically the area is oriented to Philadelphia rather than New York City and informal referral networks to the Philadelphia teaching hospitals work fairly well. But it is on a hit-or-miss basis. Two of the women interviewed at the YMCA had had unfortunate experiences, one almost dying, as a result of breakdowns in this informal referral system.

Even without benefit of medical school affiliation, improvements are being made. For example, one hospital now has a full-time director of medical education who not only supervises the residency program but carries on a program of continuing education for staff doctors. Another hospital has arranged with the new medical school at Rutgers to give monthly lectures to its staff. The better the doctor, however, the more likely he is to agree that there is need for more formal affiliation with one or more of the major medical centers in Philadelphia or New York City.

Theoretically, at least, the Regional Medical Program offers promise in this respect. However, in the absence of medical school leadership, New Jersey has lagged behind many other areas in the establishment of a Regional Program. At the present time, one is being formulated under the aegis of the state Department of Health, with the cooperation of the two medical schools and the professional associations. Application for a planning grant has just been made. Meantime, the Philadelphia Regional Program, sponsored jointly

by several medical schools, has been enlisting the interest of Trenton hospitals. How this potential conflict will be resolved remains to be seen.

The second greatest qualitative deficiency — one which Trenton shares with most of the nation — pertains to the hospital ambulatory facilities. As already noted, ideally, each hospital's facilities should be combined into one first-rate, one-class facility, with specialized units as needed.

Adequacy of Financing

In Trenton, as in the U.S.A. generally, most medical services are still privately financed. Over 40 per cent of the population of the state is enrolled in Blue Cross, a little less in Blue Shield. In heavily industrialized Trenton, the proportion is undoubtedly higher. Probably 75 per cent of hospital inpatients have hospital insurance. Blue Cross coverage is good: 120 days full coverage plus 245 of partial. The big gap is in ambulatory services.

The Blue Shield contract is conventional with a $7500 family income limit. Information is not available as to what percentage of subscribers this cuts off from service benefits. I would think well over half. This is a source of great subscriber irritation and one that will probably have to be corrected if Blue Shield is to survive as an effective middle-income insurance mechanism.

One innovation to be applauded is a rider, sponsored jointly by Blue Cross and Blue Shield, providing limited coverage of five categories of ambulatory diagnostic and treatment services — pathology, x-ray therapy, and so forth. However, only 32 per cent of Blue Cross subscribers have this rider. It is limited to large groups.

The future of private health insurance in Trenton, as elsewhere, is a moot issue. Adequacy is even more a question of scope of benefits than of enrollment. Very little progress has been made in this respect. The carriers' reaction to Medicare — this goes for Blue Cross and Blue Shield as well as the commercial companies — has been disappointing. Complimentary policies generally do little more than pick up the deductible and coinsurance. There is talk of drug coverage. I understand this is being pressed by the drug industry. But in the area of greatest single need — regular ambulatory care — there is not even a sign of a breakthrough. Whose fault this is is another question. But the objective fact remains: private insurance has shown no disposition to challenge the difficulties and obstructions that complicate financing in this area.

Some degree of responsibility for financing health care is expressed at all levels of government — municipal, county, state, and federal. We have noted the $32 million spent last year on welfare medical programs. Forty-eight per cent of this came from the federal government, 28 per cent from the state, 24 per cent from local governments.

The current budget of the New Jersey Department of Health (exclusive of sewerage funds) is about $14 million, of which $6 million comes from Washington. It is requesting $18 million next year. The Rehabilitation Commission is spending about $7 million this year and requesting $8.5 million next year. Seventy-five per cent of this is federal. The Division of Mental Health, which operates seven state mental institutions and assists six county hospitals, is spending $55 million, of which only $1.6 million is federal. There are numerous other fragments of health services scattered throughout the state's departments and budgets.

The city of Trenton is also putting in its share, about $600,000 in the current fiscal year. This includes the budget of the Division of Health—$355,000 (exclusive of $88,000 in state aid) — and the school health program of the Board of Education — $240,000.

Until the past year or two, comparatively little direct federal money came into Trenton for health purposes. In 20 years of Hill-Burton, only $2,250,000 of federal dollars were allocated to Trenton hospitals.

Medicare and the establishment of an aggressive anti-poverty program have suddenly catapulted the federal government into center stage. United Progress has made health one of its major concerns. Current spending for health is in the order of $250,000 this year. But if its proposed program is adopted this picture will change radically. The first-year budget would involve several million. This would include not only the proposed family health center, but special programs for alcoholics, narcotic addicts, mental health, and the like.

Medicare patients now account for nearly 30 per cent of all bed-days in general hospitals and for a considerable proportion in mental and long-term institutions, probably most of the "extended care" population, most of the home health visits, and a considerable proportion of physicians' services — both in and out of hospitals. Medicare's impact on Trenton's health economy is obviously substantial. Many millions are involved.

No one knows how much tax money is being spent for health in a community like Trenton. It is certainly a substantial figure and, as a proportion of total medical care expenditures, probably considerably higher than the Social Security Administration's current national estimate — 25 per cent. When a good Title XIX program is implemented, the figure will again increase, substantially. Such a program could raise the proportion to somewhere around 35 to 40 per cent depending on its income limits and other characteristics. This step should not be taken without serious thought — not just by the welfare authorities, but by the whole community, including the medical care establishment and the principal private carriers. No one is going to turn the clock back. We will probably never again have a health care economy, in Trenton or elsewhere, where less than a fourth of total medical expenditures comes from government. But do we want the proportion to reach perhaps 50 per cent? The answer lies with the capacity of private financing to meet the rising costs and, conversely, in the capacity of the medical care establishment to restrain costs to a level with which private insurance can cope. Thus far, there are few hopeful signs on either score. Then there is the further question: If public financing should move from a minority to a majority factor in the health care economy, should it be primarily in the form of public assistance or social insurance?

While these long-range issues are being debated, government has the immediate responsibility of setting its own house in order. If this is not done, the results are likely to be more inflation and frustration rather than more care for the sick.

Mechanisms for Coordination and Planning

The need for health planning is increasingly acknowledged and planning groups are springing up all over. United Fund agencies were among the first on the scene, at least in the larger cities. New Jersey is now blanketed with state and regional hospital planning councils whose jurisdiction is generally taken to include private long-term facilities as well. The Trenton area has its own council. None of these bodies has any statutory authority. They rely on two factors — influence on corporate donors and Blue Cross cooperation — to make their decisions stick.

This is clearly an advance over the previous chaotic situation. Hospitals are becoming planning-minded and commendably cautious with respect to the addition of new acute beds. In pointing out what seem to me several basic weaknesses in the present hospital planning activity, let me, as a loyal member of the state council, reemphasize the very significant progress that has been made.

First, I feel sure that some statutory authority will have to be granted — perhaps along the lines of the Metcalf-Folsom model in New York State. *Second,* it must be very clear that the planning authorities really represent the total community. It is only natural, perhaps inevitable, that the present bodies are heavily

weighted in favor of the "hospital establishment" — the hospitals themselves, Blue Cross, and prominent donors and trustees. No matter how enlightened and objective their decisions may be, it is almost inevitable that they will be establishment-oriented. If these bodies are to be endowed — as I think they should — with statutory authority, it is essential that they provide representation to *all* the community, including labor, Negroes, women's groups, and other frequently omitted categories. *Third,* They are going to have to become involved in positive planning rather than just negative nay-saying. It is not enough, for instance, to say to a hospital that wishes to expand that there is no demonstrable need, on an overall basis, for more acute beds. The planners will have to recognize the real bottlenecks and imbalances — in professional relations as well as in patient needs — and work with the individual hospitals and the medical profession in correcting them. For example, it is probably true that one or perhaps even two of the obstetrical services in Trenton hospitals should be converted to medical-surgical use. But this will not be easy to accomplish. There are good obstetricians on the staffs of the services that would be closed. Provision would have to be made for them to work in the one or two consolidated services. This, in turn, would open up the whole closed staff issue. Thorny questions of quality control will have to be faced as well as the inevitable political and human relations problems.

Turning to other health areas, planning activity is also evident. The state now has a comprehensive plan for community mental health centers. The Rehabilitation Commission is drawing up a state-wide plan of its own. Two regional medical programs will be competing for the interest of Trenton's hospitals. The ponderous machinery of P.L. 89-749 is gradually being developed.

What all this adds up to, in terms of the health of Trentonians and the adequacy of the medical care available to them, is still far from clear. Heretofore, the planlessness of the planning movement itself was both obvious and disturbing. Conflicts inherent in our fragmented medical care economy were often duplicated in the planning programs and agencies. Those who seek reforms to the planlessness are themselves accused of adding to the confusion. One of UPI's primary concerns in designing its proposed neighborhood health center is to overcome the existing fragmentation of services. Yet there are those who say that such a center, especially if free-standing, would simply add an additional fragment.

There are those who see in 89-749 primarily an instrument for "capturing" the health agencies that are now outside the Public Health Service and the state health departments for those agencies. There are those who see in the Regional Medical Program primarily an instrument for aggrandizement of the teaching hospitals and academic medicine at the expense of the community hospitals and private practitioners. Possibly there is a grain of truth in all these allegations. It may be impossible for planning ever to be completely objective. It must, however, aim for this goal. One device is to bring the public itself into the planning process in some really meaningful fashion.

To do this will be infinitely harder than merely setting up a high-level committee of professional people, and perhaps a few friendly laymen, to have lunch together once a month. To do this will mean starting from the bottom up as well as from the top down and making sure that the two movements mesh.

Fortunately, progress has been made in this respect also. UPI has done a pioneer service in grass-roots community organization among the hard-core poverty families. The new city health officer has similar ideas about the necessity of neighborhood health organization. He doesn't have enough money or backing, however. Hopefully these two efforts can be brought together. Then, the question arises shouldn't there be a public health council for the entire city (also at the county level), with representation from the neighbor-

hood bodies, as well as professionals? The nucleus of a county body already exists in the Mercer County Health Facilities Planning Council. Significantly, this body, which has already changed its name from "hospital planning council" to "health facilities planning council," is now considering a further change to "health planning council."

In short, the building blocks for a meaningful planning mechanism already exist in a community like Trenton. There are serious gaps and deficiencies — as is true throughout the country. This indeed is precisely why a new overall effort is so badly needed and greatly to be welcomed. But to be effective it will have to work with and strengthen the existing bodies. What is needed now, most of all, is leadership. Leadership knowledgeable with respect to the scientific aspects of modern medical care; leadership experienced in the complexities of its organization and financing; leadership skilled in the arts of politics and human relations; leadership that understands the problems of the submerged 20 per cent as well as the affluent majority; leadership that understands that today's affluent may be tomorrow's medically indigent and that today's medically indigent is still an American citizen and expects to be treated as such; leadership that understands the need for systemization and also for humanization.

There is all-too-little of such leadership visible in Trenton today. But I am sure it is there, waiting to emerge. The time is highly propitious. It is surely more than coincidence that, in the course of a single year the following events have taken place:

Trenton's first rudimentary medical group has been formed.

The County Medical Society has chosen as its next president an articulate spokesman for the underprivileged — a respected Negro physician.

Medicare went into effect.

Quality standards are for the first time being applied to nursing homes and home health services.

An agency with enough money to carry out its promise (or threat) is thinking of funding a comprehensive health center.

Officials of the State Department of Health are publicly calling for a "revolution" in hospital ambulatory services.

After four years without a full-time director for its Division of Health, the city has appointed an energetic young M.P.H. from Columbia University.

The Hospital Research and Educational Trust of New Jersey has just received a grant of $750,000 from the U.S. Department of Labor to develop training programs for hospital nonprofessional workers.

The Board of Welfare and Board of Control — top policy-makers for the state — have endorsed the principle of a comprehensive medical care program for the medically indigent.

The new medical school at Rutgers has its first class. The reconstructed New Jersey College of Medicine and Dentistry has taken a new lease on life, and the precedent-setting Hunterdon Medical Center has announced plans to start a new School of Health.

A special Governor's committee has recommended, and the Governor has endorsed, a single state regulatory agency for the hospital industry.

One agency — the Health Department — has been designated by the Governor as *the* comprehensive planning body for the state.

A new state Department of Community Affairs has been established under the direction of one of the nation's most dynamic urban planners.

"There is a tide in the affairs of men,
Which, taken at the flood, leads on to fortune;
Omitted, all the voyage of their life
Is bound in shallows and in miseries."

It is just possible that the next year or two represent the flood-tide in the movement toward comprehensive health planning in Trenton, in New Jersey — and in the nation. Will we rise to the challenge? Do we know how to?

31 Scott Lane

It may sound like overdramatization, but it is still sometimes possible to get away with murder—by poison.

Diagnosis Of An "Accidental" Poisoning Death*

Joseph H. Davis, M.D./Miami, Florida

The diagnosis by the medical examiner of poisoning is a retrospective process usually starting with the discovery of a body. Before a classification of accidental means of death is entertained, there is a need to diagnose the presence of poison, its significance as a cause of death, and its correlation with other evidence arising from the investigation.

It is essential that there be an adequate law to enable the medical examiner to investigate without restriction, and a legal right for him to exercise his scientific zeal to the utmost. The medical examiner should be charged with the responsibility of investigating and determining the cause of death of all sudden, unexpected, questionable, accidental, suicidal, homicidal, or public health deaths arising in his jurisdiction. Commensurate with his responsibility should be the authority to do unlimited autopsies and laboratory tests at his discretion rather than at the discretion of some other public official such as a prosecuting attorney. The medical examiner needs sufficient facilities for initial and retrospective investigations and for the performance of immediate autopsy and toxicologic studies. He should be vitally concerned with the community problems of public health, social welfare, and legislative matters pertaining to health and medical practice.

With this background, he will be able to develop a considerable amount of community knowledge of such a nature that a geographic location, an address, or even a family name may suggest a line of investigation into a possible poisoning. He should have firsthand knowledge of the circumstances surrounding a death and familiarity with the symptoms and signs of rapid death from various poisons.

In an agricultural community, knowledge of the common pesticides is of great value in anticipating suspicious circumstances and indicating what poisons should be suspect. The same philosophy should apply to an industrial community where toxic agents are in common use. Some people, by their very nature, will abuse the safeguards placed about many of these poisons. In an agricultural community, one can depend upon the illegal or illicit use of restricted pesticides in and about the home by ignorant individuals or by those of a criminal nature.

If the needed facilities are available, the poison death investigation becomes multiphasic. The initial scene investigation into the circumstances, the external and internal examination of the body, and subsequent laboratory tests vary according to the circumstances. In some cases, the scene must be reinvestigated. Also, there may be need for additional laboratory tests before the cause of death may be finally considered. A typical example of such a case is this:

I

An 18 year old boy was found dead in his home. The body was transported to a pathologist for an autopsy

* Read before the Symposium on Accidental Poisoning, Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 16, 1967. Dr. Davis is Chief Medical Examiner of Dade County, Florida, and Professor of Legal Medicine at the University of Miami.

"to determine the cause of death." No findings were noted at autopsy other than non-specific visceral congestion. Some suspicious white material was noted on the fingers. Stomach content, large portions of viscera, and scrapings of the material from the hands were submitted to a forensic pathology laboratory in another area of the state. The gross inspection of the viscera and stomach content at the laboratory revealed no objective signs of intoxication either by odor or appearance. A few simple tests for more rapid acting poisons, common to that region, were negative. A telephone call to the autopsy surgeon was made with the suggestion that the scene be investigated by him for non-toxic common causes of death in otherwise healthy individuals. Specifically it was suggested that a source of electrocution be ruled out before any additional chemical studies were attempted. Based upon this suggestion the cause of death was found to be an energized electric stove which had a short circuit. The boy was supposed to clean the stove, which accounted for the white material on the hands, a common scouring powder. The moral of this story is that the autopsy and the laboratory facilities must he guided by adequate scene investigation and knowledge of common causes of sudden death in various age groups and under various circumstances.

II

An 11 year old child began to cry, lapsed into a coma on a school bus and was dead on arrival at the hospital. Initial superficial investigation revealed nothing. A "routine" inquiry as to medications or illness elicited only a history of a common cold and the ingestion of a therapeutic amount of a common harmless cough medication shortly before boarding the school bus. Routine chemical tests revealed an ultraviolet spectrophotometric curve on the stomach content consistent with the cough medication. Careful, but "routine" autopsy revealed no findings of additional positive significance. Because of these circumstances, additional chemical studies were done, which included reevaluation of the ultraviolet spectrophotometric curve of an extract from stomach content. A small variation in this curve led to a suspicion of a compound having absorption characteristics similar to strychnine. Additional extractions and tests confirmed the presence of strychnine. Armed with this knowledge, detailed interrogation of the witnesses elicited the classical signs of strychnine poisoning. Reinvestigation by police led to suspects but there was insufficient evidence to justify an arrest. One might speculate the outcome of this case had there not been the cough medication which obscured the strychnine ultraviolet absorbence. This case exemplifies the need for rapid diagnoses in cases of poisoning and the problems which arise in the course of investigation.

III

An elderly man was found dead on the kitchen floor. An agonal contusion of the forehead was consistent with a sudden collapse to the floor while dead or dying. Because of his age and the evidence of apparent sudden death, he was considered to be the victim of a heart attack. Lack of prior medical history coupled with a policy for autopsy confirmation of presumed diagnoses led to the discovery of a massive amount of a rapid-acting, highly alkaline barbiturate mixture in the stomach. The sudden collapse and rapid death in this individual was due to the suicidal ingestion of a massive amount of a common hypnotic containing secoharbital and amobarbital. In this case, the entire investigation was conducted along the lines of "presumed natural heart disease." The autopsy discovery of characteristic alkaline inflammatory reaction of the stomach directed the investigation into the correct channel.

IV

An alleged "narcotic addict" was rushed to a hospital and pronounced dead on arrival. According to a witness, death was due to the self-administration of an overdose of heroin. Because heroin may be administered for malicious reasons, the blood of the victim was smelled by a person with good perception for abnormal odors. A faint odor of cyanide was noted. Both on the basis of odor and subsequent chemical determination, cyanide was detected in greatest quantity at the injection site and was absent in the stomach and liver. A telephone call to a narcotic law enforcement agency revealed that the victim was definitely not an addict nor did he associate with addicts. Subsequent investigation of this presumed "accidental death from self-administration of heroin" revealed it to be a carefully premeditated and carefully contrived murder by intravenous injection of cyanide in which the heroin story was planted to fool the authorities.

As may be seen from these few cases the differential diagnosis between accident, suicide, and homicide may depend on many factors. Basically it is a problem of the preponderance of evidence. As the investigation proceeds, negative and positive information is acquired from all possible sources to reach a reasonable and correct medical opinion as to the probable classification of the death. It is necessary to take into consideration the experience of the investigator, the circumstances surrounding the death, the autopsy findings, and the laboratory tests. Every effort should be made to arrive at good definitive evidence in order to sustain a reasonable opinion as to the classification of death.

The initial detection of a case of poisoning death is not based upon a single set of characteristic signs or historical symptoms. An investigative agency needs to have the following attributes:

1. High index of suspicion
2. Background knowledge of the community
3. Familiarity with variables of clinical manifestations
4. Careful initial and subsequent scene investigations
5. Prompt utilization of laboratory facilities bearing in mind the limitations of testing procedures.

As a result of these attributes, coupled with an adequate enabling act and facilities, there have been accumulated in the files of the Office of the Medical Examiner of Dade County, Florida,[1] data upon more than one thousand consecutive deaths by poison from 1956 through 1965. Of all poisonings (including

suicides and homicides) medications comprised 59 per cent; pesticides 10 per cent; carbon monoxide 16 per cent; and alcohol 11 per cent. Out of 313 accidental poison deaths, 38 per cent were due to medications, 12 per cent due to pesticides, 10 per cent were due to carbon monoxide, and 35 per cent to alcohol.

With accidental death of children under five years of age (45 cases) medications comprised 24 per cent; pesticides 49 per cent, carbon monoxide 4 per cent, alcohol 2 per cent, and polish 9 per cent. Twenty-two of the forty-five accidental deaths by poison in small children were due to pesticides. Among these were parathion, 14 cases; Guthion,® 1 case; white phosphorus, 2 cases; arsenic, 2 cases; thallium, 1 case; acrylonitrile fumigant, 1 case; and fly spray, 1 case. Contrary to reported national figures[2] (where 31 per cent of poison deaths in children were designated as due to aspirin and salicylate) we found that aspirin accounted for only eight deaths out of forty-five (18 per cent). Of these aspirin cases four were due to overtreatment of children by ignorant adults for otherwise minor illness.

The preponderance of pesticide deaths, particularly parathion, has been the result of large scale local use of this chemical in agriculture. Some one-quarter of a million pounds of parathion preparations are used each year in Dade County alone. The problem arises when, through ignorance or avarice, the material is sold to home owners or brought into homes contrary to good practice.

Summary

An "accidental" label should not be placed on a death in the absence of meticulous investigation. Too often, a death is presumed to be "accidental" in the absence of an autopsy or background investigation. In the face of an autopsy finding of poison (or some other unnatural cause) one may easily fall into the trap of making an "accidental" classification without careful investigation and correlation of laboratory and physical evidence with the statements of witnesses. The classification of a poison death as "accidental" should never be by default. When faced with a lack of preponderant evidence, it is better to leave the designation as unclassified or undetermined.

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8905 S.W. 115 Terrace

New Health Education Material Now Available

The Health Insurance Institute has announced publication of a new booklet, "Health Education Materials — And The Organizations Which Offer Them." This brochure contains a useful list of sources which make available material on health subjects. The national organizations listed offer either free or inexpensive information and educational materials. Sources of free literature to students are also specifically identified.

The materials available from these organizations are broken down by topic, such as accident prevention, aging, air pollution, child care and development, dental health, eyesight, first aid, foot health, health, health careers, hearing, mental health, nutrition, physical fitness, and rehabilitation.

Free copies can be obtained by writing to Department H, Health Insurance Institution, 277 Park Avenue, New York, 10017.

Pituitary and ovarian radiation are still effective in anovulatory cycles in selected cases according to this report from the Metuchen Obstetrical and Gynecologic Group.

Treatment Of Idiopathic Anovulatory Cycles By X-Ray Stimulation

William H. Ainslie, M.D./Metuchen

The use of roentgen rays as a stimulant to the ovaries and to the pituitary gland has met with considerable controversy. However, few facts concerning this method have ever been published. I am here presenting a series of twenty cases, collected by myself, over a period of eight years. This represents only those sterility problems with proved anovulatory cycles that, in my opinion, had no known etiology. It included couples willing to try the Kaplan cycle[2,7] after it had been explained to them. This group represents about four per cent of the primary sterility patients seen during these eight years. Actually this series of twenty cases has been reduced to nineteen with follow-up, as one patient moved away after therapy.

Our typical preliminary work-up consisted of a complete physical examination for the wife, while the husband was referred to an internist. A temperature chart was kept and a smear cycle study was supervised and interpreted by our cytologist. Rubin and Huhner tests were done. If there were any "suspicious" pelvic findings (and in the latter part of the series almost routinely) a hysterosalpingogram was performed. Skull X-rays were taken. We did a glucose tolerance test, 17 keto-steroid, 17 hydroxy-keto-steroid, and pregnandiol and FSH determinations. A sperm analysis was done on the husband in all cases where the Huhner test was not up to expected results. After this work-up, those cases which were proved to be anovulatory (by temperature chart, smear, and in some cases, by endometrial biopsy), and where no other cause could be found, were given medical treatment. This included three approaches and in most cases, all three were tried. The *first* was cyclic therapy with estrogen and progesterone. The *second* was suppression with one of the progestational agents for several months in hopes that the "rebound" would stimulate ovulation; and the *third* was intravenous premarin. Patients who did not respond to these methods (after a reasonable time) were then presented with the possibility of a Kaplan cycle. Those who elected to try the Kaplan cycle were referred to the radiologist, who interviewed and explained the details of treatments to them. He made no great promises. He personally supervised the treatment of these patients.

All patients were given the regime developed by Dr. F. A. Kaplan of Bellevue 40 years ago. This treatment consists of 75 R given in air to 4 by 44 cm portal directed over the forehead to the pituitary gland, with a half millimeter of copper and one-inch of aluminum as filters at 200 KB. This first dose also consisted of 50 R in the air to each ovary anteriorally through a 10 by 10 cm port. One week later, the second dose is given, with the pituitary dose the same but 75 R are given to each ovary from a posterior approach. The dose can be repeated in two years.

There are no known contra-indications or complications. All schedules are started after a menstrual period, even if it has to be induced, to rule out the possibility of early pregnancy. There were no complications in

any of this small series and all babies who reached viability were normal. In 1950, Kaplan[6] reported on a follow-up of three generations of treated mothers. Eight hundred treated mothers delivered five hundred and fifty-six children. Not one single baby was abnormal and 44 grandchildren were normal. The number of males equaled the number of females. No malignancies were reported in the children and the grandchildren.

Analysis Of The Series

The average age of these twenty patients was 30 years when first seen. The youngest was 19 and the oldest was 36.

The average age of menarche was 12.8 years. The range of menarche varied from 11 to 17 years. Eleven patients had grossly irregular menstrual cycles when seen for sterility work-up, and nine of these had been irregular since menarche. The duration of these irregularities ranged from six months to five years. Three patients had regular menstrual cycles every 28 days. One patient menstruated only when induced by medication. Another had only four spottings in her life time. Three additional patients had a cycle that varied from 28 to 35 days. The last had a regular cycle every 35 days. The average duration of menses was about 4.6 days. Proof of anovulatory cycles was based on the evidence of a flat "picket fence" temperature chart plus a vaginal smear that showed no post ovulatory phase, and in certain cases an endometrial biopsy showing proliferative endometrium pre-menstrually.

Prior surgery was noted in the history of seven patients; two had had curettages for abnormal vaginal bleeding; one had had an oophorectomy for a benign cystoma, four had had acute appendicitis with appendectomy. Each of two patients had had a single child before she became anovulatory. One had begun treatment for anovulatory cycles even before she was married. A total of 12 patients had had treatment before I first saw them. Nine of these had had complete work-ups in the process of being treated. The average patient had been attempting pregnancy for 6.8 years before coming to my office.

Evaluation

Thyroid gland evaluation revealed normal function in 19 out of the 29 patients. Both the BMR and the PBI were checked. The Huhner test indicated that four husbands had low sperm counts. In addition to low counts, two husbands had very poor motility. These four cases accounted for two failures and two pregnancies that both aborted. Glucose Tolerance tests were done on ten patients and all had normal curves.

An additional seven had post prandial blood sugars, all of which were within normal limits.

Rubin tests were done on all patients and no obstructed tubes were encountered. Nine patients, in addition, had hysterosalpingograms and all were recorded as normal. Temperature charts on all patients were of the low "picket fence" variety with no post ovulatory plateaus. Smear cycle studies were done on all but one case; and none showed any ovulation. Pap smears were done on all patients and again no abnormalities were encountered. Skull X-rays were recorded on 14 patients and none reported any abnormalities. 17 Keto Steroid determinations were performed on 13 patients and in 3 of these patients the studies were repeated. The average was 10.7 milligrams. The highest recorded test was 22 which became 10.7 on the second test. Next, 17 hydroxy-keto steroids were performed on 7 cases for an average of 6.21 milligrams. Pregnandiol determinations were done on 11 for an average of 1.3 milligrams. Eleven patients had FSH determinations, all of which were recorded as within normal limits. Thus, in this group, none of our endocrine assays revealed any abnormalities.

The emotional status of each couple was evaluated. None was felt to demonstrate any abnormal degree of instability and none had any significant psychiatric background.

Treatment

Many treatments were tried before the Kaplan cycle. Eighteen patients were given six months of cyclic replacement therapy consisting of estrogen and progesterone. Eleven had at least 3 separate monthly injections of intra-

venous premarin. Ten patients were given suppressive therapy which would either be Provera® or Enovid,® 20 days a month for at least 3 months, in hopes that on the rebound they would ovulate. Ten patients had empirical treatment of desiccated thyroid. None of these methods produced provable ovulation in this series.

Results

Nineteen patients have been followed and of these sixteen or 84 per cent showed ovulation within two months of treatment. Evidence of ovulation was indicated by temperature chart and either smear cycle or endometrial biopsy.

Thirteen patients, or 69 per cent of those treated, became pregnant within three months of treatment and nine or 47 per cent produced eleven alive normal children. There were no abnormalities noted in any pregnancy.[6] The four patients who lost pregnancies all did so within the first three months of gestation. Seven patients became anovulatory again within the year and two of these failed to respond to a cycle repeated two years after the original.

Discussion

Evidence concerning the value of low dosage irradiation of the ovaries has been presented by Edeiken (1) Kaplan (2) (7) Mazer and Greenberg (3) Rakoff (4).

There are two theories as to ways that low dosage irradiation may affect the ovary. One is that there is direct stimulation to the ovarian follicle as suggested by Rakoff.[4] The other theory (presented by Rock[8]) suggested that the favorable effects may result from the destruction of cystic atretic follicles. The recent work of *Moawad, et al.*,[5] suggests that small doses of X-ray irradiation may hasten the ripening of young follicles, thus agreeing with Rakoff.[4] The conclusion of this discussion is that low dosage X-ray irradiation of the ovaries is but one of several methods to stimulate maturation of follicles. The other methods are chemical and surgical. I do not suggest, in the light of recent developments of stimulating follicle maturation and ovulation with chemical modalities, that this is a superior method, but rather one that should not be overlooked when a patient is being evaluated. A doctor should have several alternatives in his armamentarium of therapy. Certainly X-ray irradiation should be considered where other treatments are either unavailable or have failed or are contra-indicated for some other reason.

Summary

1. Small series of patients with idiopathic anovulatory cycles has been presented and treatment by X-ray stimulation outlined.

2. The pregnancy rate in this series was 69 per cent of those so treated. Live babies were delivered to 49 per cent of the mothers in this group.

3. All but three patients ovulated within three months.

4. The establishment of ovulation by X-ray stimulation is transient in most cases, usually lasting less than a year. Nine of this series reverted to anovulatory cycles.

5. Pregnancy in this series usually took place in the first three months after treatment.

6. This method for treatment is simple and can be carried out by a competent radiologist with minimum of equipment and expense.

I am indebted to the late Mr. Arthur Dicker of the Metuchen Clinical Laboratory who performed much of the laboratory work. I want to thank my cytologist, Mrs. Virginia Leonard, who reviewed all of these smear cycles as well as all of the papanicolaou smears in this series. Thanks are also due to Dr. John Helff of New Brunswick, who was the radiologist in this series and who was helpful with his comments on this paper.

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73 Amboy Avenue

The management of learning difficulties calls for an effective partnership of physicians, educators, social workers, and psychologists.

The Child Psychiatrist's View Of Learning Problems*

Richard M. Silberstein, M.D.
Staten Island

Learning difficulty is the most sensitive indicator of emotional difficulty as well as failures of the developmental process in childhood. Like syphilis and hysteria, learning difficulty is a great imitator and can be caused by a wide variety of psychologic, physiologic, and environmental difficulties, as well as the more obvious educational failures which account for so many underachievers. Learning difficulty may be rooted in disorders ranging from subtle types of brain injury, obscure aphasias, visual and auditory deficiencies, and mental retardation to a number of psychotic, neurotic, and character disturbances generally classified as functional entities in the psychiatric nomenclature. In terms of incidence, however, the sequelae of poverty and cultural clash are responsible for the largest number of non-learning youngsters in our society.

In some areas of our large cities, as many as 50 per cent of children in improverished communities show marked learning deficits. The side effects of poor general health also swell the ranks of children with learning difficulty, since adequate energy and freedom from anxiety are necessary for a child to learn effectively. Cultural conflict may also produce non-learners. This can be seen clearly in the Spanish speaking child who is obliged to learn to read in English when he doesn't speak English, or the Jewish child who is obliged to learn to read in Hebrew from right to left at the same time he attempts to read in English from left to right. Subtle conflicts in instruction have decimated our schools and reduced the norms in standard achievement tests a full two years during the past thirty years.

Thus, the attempt to convert the teaching of reading from the phonetic method to the look-say or word recognition method of reading instruction has created a frightening number of poor spellers, poor readers, and inarticulate secondary students who can speak brilliantly but remain unable to communicate in writing. Since learning difficulty is rapidly cummulative, the problems of poor-learning children multiply geometrically.

By adolescence, the poor-learner is overwhelmed by his past failures and must either sit passively in class as a failure or drop out of school and remain an educational cripple for the rest of his life. This is complicated by the apparent existence of critical periods for learning – times during which learning goals must be achieved or forever become impossible. Accordingly, the poor reader or the poor mathematician is very difficult to help after adolescence, since the physiological capacity for basic learning appears to diminish rapidly after puberty. This is obvious to language teachers who observe that grade school children can acquire a second language with great ease and virtually no accent but after puberty frequently seem unable to learn a second language without flaws in accent or pronunciations. Similar capacities seem present for the grade school child who is learning

* Read before the Section on Psychiatry and Neurology, Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 15, 1967. Dr. Silberstein is Director of the Staten Island Mental Health Society.

to read, spell, and conceptualize mathematically. These capacities disappear rapidly and the poor learner is further handicapped by the repeated pain of frequent failure against which he attempts to shield himself by rejecting all matters academic.

The secondary consequences of learning failure are catastrophic, since children attempt to find a niche for themselves in antisocial acts when they cannot find rewards in socially approved behavior. The child left back in the fourth grade is a head taller than his classmates and more sophisticated. If he is vigorous he may seek status in bullying rather than marks. If this pattern of behavior continues, the entire course of his life reduces its scope and the child becomes a learning cripple. Learning difficulty, then, has as serious life-long consequences as heart disease, diabetes, or rheumatic arthritis. Since these matters usually come to the attention of teachers and family physicians first, it is incumbent upon physicians and teachers to be as sophisticated in diagnosing learning problems as it is incumbent upon physicians to be adept in diagnosing and treating the wide range of organic diseases seen in general medicine.

Learning problems peak in the first, third, seventh and ninth grades. First graders who are hyperactive, unable to sit in class, or concentrate on academic material, or, who have not achieved the developmental level necessary to learning, arrive in the physician's office toward the end of the first semester. These youngsters usually include the brain-damaged, the psychotic, and the environmentally damaged child, as well as the undisciplined, the immature, and the unprepared youngster. Distinguishing among these diverse entities is a tedious task, often requiring the combined talents of a variety of specialists who are capable of studying in detail the neurological status, psychological status, emotional status, developmental status, and environmental status of the child, as well as evaluating the educational atmosphere in which the child's problem appeared. The classical neurological examination alone is often negative even when minimal brain injury exists, so that specialized tests of perceptual-motor functioning are often indicated. Accordingly, children with learning difficulty require the team-specialist approach of the child guidance clinic, if an adequate treatment program is to be developed. Reassurance that a child will "grow out of" his problem is not only false, at times, but may prevent the prescription of adequate therapeutic regimes which, at the first grade level may simply and completely remedy the problem.

The third grade peak of poor learners brought to the physicians' office for the first time not only includes the same range of youngsters but also includes the child who conceals his problem through outward compliance as well as the child whose teacher has failed in the task of capturing the child's attention. The third grade net, though, catches the non-reading youngster or poor reading youngster who cannot go much farther in the school system without correcting this deficiency.

The seventh-grade poor learner may be another kind of problem altogether. Seventh graders are entering puberty and are undergoing the psychological regressions characteristic of this period of life. Assuming no learning difficulty has existed until seventh grade, the new development of learning problems at this time may well be transitory.

Ninth grade learning problems are the harvest of years of poor learning skills, undiagnosed neurological problems, unmanaged family or social problems, unresolved educational errors or accidents, persistent infantilisms which interfere with learning and all of the other anxieties and psychological aberrations which families have denied, schools have covered over, children have concealed, and physicians have ignored over the years. Now the problem must be managed if this child is to survive in school at all, but at a time when management is extremely difficult because of the child's long standing poor habits and repeated failures as well as his physical size. The child is now capable of re-

jecting school, family, and child guidance clinic out of hand because he is big enough to rebel successfully.

Learning difficulties later in adolescence which are not cumulative have different roots. All of us are familiar with the acute psychological explosions which surround the adolescent era. These contribute to a small number of interrupted school careers. Curiously, though, most youngsters experiencing the pain of growing up physically as well as psychologically, who have learned well before, do not lose their academic abilities. They give their families wrinkles and gray hair but usually progress satisfactorily in school if the roots of learning are well established. That is, they do so if their teachers and their families do not succumb to the lure to battle which so often characterizes the adolescent's search for independence. Rather, false starts at independence which result in leaving school or giving up due to independent longings are more often responsible for school failures in adolescence. Since adolescents also vacillate from hedonism to asceticism, the energy consumed in these retreats from reality often results in reduced school performance.

The first year college student also suffers from these vacillations. More often, though, the first year college student flounders because of his inability to become self-directed when his parents are no longer around to supervise his daily study program and provide reins on his social life. The longing for independence in these young people, the guilt at new patterns of behavior, violations of family standards, along with the more competitive academic routine in college combine to contribute to college failures.

These are the major periods of life at which one or another cause of learning difficulty predominates. It may be well to keep in mind however, the major categories of causes of learning difficulty before discussing treatment and management. As noted, educational errors and accidents constitute a significant number of the learning problems of American children. This does not mean teachers are to blame for these errors and accidents. Conflicts between school standards and home standards, incompatibility between teacher and child, peer incompatibilities, classes which are too large or too disparate in composition (such as the bright child in the dull class or the dull child in the bright class) all play a role in this problem. When a teacher gets sick or gets married or gets pregnant, the children in the class are troubled. Note, though, that 60% of children learn no matter what happens. It is the 40% of children that concern us as members of the child guidance team.

Social disturbances, inadequate mothering, the sequelae of poverty go hand in hand with educational errors in the creation of learning problems. Unemployed parents, broken homes, inadequate mothering, failure to exploit normal development or to motivate children for learning are all based on poverty and perpetuate the cycle of learning troubles from generation to generation. Here, antisocial behavior and learning difficulties go hand in hand.

Parental uncertainty, the inability to know when to control and when to pressure, when to encourage ingenuity and innovation and when to say "stop" also plays a part in the causes of learning difficulty. Insistence on perfection rather than emphasizing the benefits to be gained from errors, finding truth through mistakes, reduces the effectiveness of many of our youngsters today. Faced with merciless competition, children must find the route to problem-solving through their own efforts. It is here that misguided middle-class parents hamper rather than help their children.

The persistence of infantile behavior also constitutes a major source of grade-school-age problems. Children who relieve tension through gum-chewing, thumb-sucking, bedwetting, hair twirling, and other nonproductive discharge mechanisms may relieve tension at the price of their academic skills. The old-time "school marm" who forbad gum chewing and demanded attention from children may have been doing more for youngsters than

many modern educators believe. In an unpublished study carried out at the Staten Island Mental Health Center, children who were assisted to give up bed-wetting showed a dramatic upward curve in school performance.

Poorly resolved anxieties, whether from realistic or from unrealistic sources, also play a significant role in the genesis of learning difficulties. Children struggling with conflict, daydreaming, or distracted by troubles, whether real or neurotic, often do poorly in school unless school is a pleasurable escape hatch for their worries. Frank mental illness, psychosis, plays a comparatively small but important role in the total number of learning difficulties which exist in our country today.

Similarly, organic causes of learning difficulty play a numerically small role in the total number of learning problems. Even mental retardation is currently viewed as one end of the normal range of intelligence (some children in the world falling at the bright end of the curve and others at the dull end) rather than as an illness. Barring other problems, even retarded youngsters can learn at a predictably steady rate within the limits of their capacity.

Acute and chronic situational troubles, from physical illness to family instability, by contrast play a major role in children's learning troubles, just as bad behavior improperly managed by home or school must impede effective leaning for many youngsters.

What about treatment then? In general, education is the most useful treatment of learning difficulty. All the psychotherapy in the world will not make a non-reading child read, nor will psychotherapy teach a child mathematics or spelling. Psychiatric treatment can remove psychological impediments to learning just as new medications can assist a child to reduce activity and to expand his span of attention. Neither of these treatments, however, will replace expert and special instructions. The major treatment for learning difficulties is still education.

This is also true for the brain-injured, the psychotic and the retarded non-learner. Brain-injured children can vastly enhance their perceptual abilities and their motor control through proper educational efforts. Similarly psychotic and other severely disturbed children can now be salvaged through special education methods combined with psychiatric care and family counseling, just as seizure disorders, controlled by proper medical treatment, can be minimized as impediments to effective learning.

This country is also taking enormous and revolutionary steps toward solving the genesis of learning problems due to poverty. The Anti-Poverty program is the first major step taken in the history of the world to see that the children of all classes receive equal educational benefits. The Head Start program is the most extensive preventive psychiatry ever undertaken in public health history, far exceeding in scope and impact on human beings the marvelously dramatic and successful polio immunization program. As always, preventive efforts are far more valuable than therapeutic efforts. The live measles vaccine program now underway will virtually eliminate the hundreds of thousands of cases of measles encephalitis past generations have experienced.

There is a newly developing philosophy among educators designed to break the invisible barrier hitherto barring parents from schools. A new partnership is developing between teachers and parents which can only benefit children. Newer methods of parent education and parent guidance are highly effective in preventing learning problems as well as modifying the course of learning problems once they have developed.

To child psychiatrists, though, some educational innovations may prove to have antitherapeutic consequences. The too-early introduction of advanced skills (such as reading instructions at age two) may be very successful. Two year olds certainly can be taught to read. This move, though, may prove dangerous to the normal development of children and not be detected as a danger until two year olds, now exposed to these innovations,

reach puberty. It takes a generation to test educational innovations and no short-lived laboratory animal is available for testing out educational theories.

Child psychiatrists, then, see a wide range of causes of learning difficulty and apply a broad spectrum of treatment programs in the effort to relieve the crippling effects of learning problems. All of these efforts, though are based on the vigorous leadership of educators and the partnership between school, physician, educator, and the mental health team.

Our knowledge is rapidly expanding each day. Our grandchildren can look forward to a society in which few children are permanently handicapped by learning difficulty.

144 Clinton Avenue

The Good Beatniks

Not all beatniks are bad. So says Jules Masserman, M.D., in the March 1967 Archives of General Psychiatry. Dr. Masserman classifies beatniks into three groups:

Up-Beatniks—The best of the lot, says Dr. Masserman (who is professor of psychiatry at Northwestern University). Even with their occasional beards, tresses, play-readings, placards, proclamations, and protest marches, they are "basically earnest, energetic, intelligent, and well intentioned." They are a help "in prodding us oldsters to review our smug hypocrisies and revise our medieval customs and conduct."

Down-Beatniks—Articulate in condemning the inequalities and injustices of society, often with some courage and justification. They are strident and obnoxious in speech and manner, but the outlook for their improvement is often favorable. "With further maturity and increasing wisdom, most of them become good citizens, competent parents, and sometimes even staunch Republicans," said Dr. Masserman.

The Off-Beatniks—These are the more seriously erratic, troubled, and troublesome misfits. Despite their pretensions, they contribute little that is truly constructive or original to our culture.

What makes a beatnik? The teenager is looking for "identity" in a world of great complexity, Dr. Masserman explained. "The late adolescent may spread himself thin trying to be simultaneously a dutiful child, a brilliant scholar, a winning athlete, a popular leader, a potent lover, a seductive nymph, a cynical sophisticate, and a dozen other incompatible alter egos." Most youngsters seek status in groups offering support, with certain patterns of dress, modes of speech, and stereotyped musical tastes.

Dr. Masserman said most such cliques are harmless and may even be beneficial as interim experiences. He cautions:

"The dividing line is this: When an adolescent becomes so immersed in extracurricular activities as to neglect his education, physical health, and broader social development; or when he advocates 'sports' that endanger others, such as drag racing; or when he promotes public obscenity, sexual arrogance, and physical violence; or experiments with excessive amounts of alcohol or drugs, then therapy is necessary."

STATE ACTIVITIES

Trustees' Minutes

Two regular meetings of the Board of Trustees were held during the course of the 1967 Annual Meeting in Atlantic City, and, since then, the regular June meeting. Detailed minutes of these meetings are on file with the secretary of your component society. Below is a compilation of significant actions by meeting.

May 12, 1967

The final meeting of the Board of Trustees for the administrative year 1966-67 was held in Atlantic City on May 12, 1967.

F. Clyde Bowers, M.D. . . . Adopted the following memorial resolution and authorized a contribution, in the amount of $50, to the Medical Student Loan Fund in memory of Dr. Bowers:

F. CLYDE BOWERS, M.D.

1908 — 1967

Whereas, the late-lamented F. Clyde Bowers, M.D., our 167th President, served as a distinguished and faithful officer and member of The Medical Society of New Jersey for more than thirty years; and

Whereas, as a diligent and gifted member of the State Board of Medical Examiners, he rendered sustained and valuable service to the medical profession and the people of New Jersey; and

Whereas, in his practice and throughout his life he consistently exemplified the exalted qualities of mind and heart which typify the highest standards of professional and personal conduct; now therefore be it

Resolved, that the Board of Trustees of The Medical Society of New Jersey records profound grief at his passing; and be it further

Resolved, that a copy of this resolution be spread upon the minutes of this meeting, and another copy, suitably prepared, be presented to his bereaved family.

Historian-Archivist . . . Accepted, with appreciation for his efforts over the years, the resignation of Dr. Fred B. Rogers as Historian-Archivist. . . . Appointed Dr. Morris H. Saffron of Passaic to succeed Dr. Rogers.

Report of Legal Counsel . . . Approved the following report of Legal Counsel, and directed that it be referred to the county societies for their information and reference:

The Muhlenberg Hospital has sought an opinion of the Union County Medical Society concerning necessity of producing for the Prosecutor a record of therapeutic abortions and suspicious curettages. It was Counsel's opinion that all hospitals should, by staff memoranda, insure that therapeutic abortions and other related operations (henceforth, at least) are performed only on the basis of jeopardy to the mother's life. In the event such an instruction is being followed, notification of such operations on a voluntary basis should not be feared. It does not appear that there would be any obligation on the part of the hospital to volunteer that information. However, in view of recent interest shown, cooperation might forestall extensive investigation.

Statements on External Cardiopulmonary Resuscitation . . . Approved the inclusion of the following sentence in the joint statements adopted by MSNJ, the New Jersey State Nurses' Association, and the New Jersey Hospital Association on External Cardiopulmonary Resuscitation: (JMSNJ, May, 1967, p. 229)

Minimum training standards and qualifications of the nurse shall be those of the 2nd Bethesda Conf., Am. Coll. Cardiology, Dec. 1965, and Am. J. Card., May 1966, pp. 736-47.

Current State Legislation . . . Considered the following bills of medical import and approved the positions recommended by the Council on Legislation, as shown below. An asterisk (*) indicates that this bill is identical with measures of last year, or preceding years, whose positions were the same.

S-19 —To create the Division of Postmortem Examiners in the State Department of Health. *NO ACTION*

At its preceding meeting, the Council deferred action on S-19, pending the introduction of an Administration-sponsored bill dealing with the same subject. Subsequently, A-785 was introduced and is dealt with in detail in these minutes. In view of its action on A-785, the Council unanimously recommended that the Council take a position of "no action" on S-19.

S-57 —To provide that Sections 1 and 2 of Chapter 170, Title 2A (concerning drugs), shall not apply to licensed medical practitioners acting in the regular course of their business or profession. *APPROVED*

At its preceding meeting, the Council deferred action on S-57, pending information from the

sponsor concerning what she hoped to accomplish through this measure.

The Executive Director was assured by the sponsor of the bill — Senator Mildred Barry Hughes — as well as by the author of the measure — that the amendment has no application to physicians. The law recognizes that a physician is, in effect, on duty 24 hours a day. The purpose of this measure is to assure that those under certain limited circumstances may handle drugs but will not have full freedom to have such drugs in their possession when they are not actually serving under the specific circumstances which legally permit their dealing with drugs.

S-346—To appropriate $1,500,000 to acquire and/or improve property in the South Jersey area to constitute a South Jersey branch of the New Jersey College of Medicine and Dentistry. *APPROVED*

*S-356—To extend coverage of the Workmen's Compensation Second Injury Fund to include all disabilities which are likely to be a hindrance to employment, to provide for employer reimbursement of payments exceeding 104 weeks of benefits, to provide for hearings and to increase the fund to $3,000,000 in place of the present $1,500,000. *APPROVED*

S-357—To authorize the Board of Governors of Rut-
A-707—gers State University to develop the Rutgers Medical School from a 2-year to a 4-year institution by 1972. *APPROVED*

S-359—To provide for establishment of an Interstate Sanitation Commission for control of future pollution and abatement of existing pollution in the tidal and coastal waters of adjacent portions of the signatory state. *NO ACTION*

The Council considered S-443 at this time and agreed that it was a better measure than S-359. Therefore, in view of its approval of S-443, the Council recommended a position of "no action" on S-359.

S-360—To delete certain appointment privileges and to provide for appointment of public members to the Board of Barber Examiners; Board of Examiners of Nurses; and Board of Examiners of Ophthalmic Dispensers and Ophthalmic Technicians; the section concerning public members shall also apply to Boards of Certified Public Accountants; Architects; Beauty Culture Control; Electrical Contractors; Dentistry; Mortuary Science; Professional Engineers and Land Surveyors; Medical Examiners; Optometrists; Nursing; Pharmacy; Professional Planners; Psychological Examiners; Real Estate Commission; Shorthand Reporters; and veterinary Medical Examiners. *DISAPPROVED, WITH ACTIVE OPPOSITION IF BILL MOVES* . . . because professionally unqualified lay members would encumber the boards with no appreciable advantage to the public.

A public hearing on this measure has been called for Wednesday, May 17 in Trenton. The Council recommended — upon motion by Dr. Campo, seconded by Dr. Johnson, and carried — that the President of MSNJ send an official statement of opposition to S-360 for presentation at the public hearing.

S-369—To provide that contracts or agreements entered into by the Board of Trustees of the New Jersey College of Medicine and Dentistry may require the municipality to undertake obligations and duties to be performed subsequent to the expiration of the term of office of the elected governing body which entered into, or approved, the contract or agreement. (Law, Chapter 18) *APPROVED*

*S-385—To provide that the services of a chiropractor shall be considered medical or surgical services under the Workmen's Compensation Act, any health and accident, disability or other insurance policy or under any labor management trustee, union welfare, employee benefit or any private insurance or welfare plans. *DISAPPROVED, WITH ACTIVE OPPOSITION IF BILL MOVES* . . . because chiropractors receive a limited license to practice chiropractic. They are not licensed or recognized as physicians or surgeons and are not qualified — or licensed — to supply medical and/or surgical services for injuries and/or disease conditions.

S-397—To provide for civil commitment of drug addicts. *APPROVED*

S-408—To provide that any applicant for a license to practice medicine and surgery who, in addition to other required proofs necessary to be admitted to examination, shows he has engaged in the practice for 10 years and has reached a position of eminence in his profession shall be granted a license without further examination upon payment of the required fee. *DISAPPROVED* . . . because it would mandate present discretionary powers of the Board of Medical Examiners, with no constructive purpose.

S-409—To provide state aid to the extent of one-half of the operating expense of schools of professional nursing or $600 per student, whichever is the lesser amount. *APPROVED*

S-443—To create a "Mid-Atlantic States Air Pollution Control Compact," creating a regional agency for the control and abatement of air pollution and other purposes; and defining the functions, powers, and duties of such agency. *APPROVED*

S-447—To mandate use of safety equipment on motorcycles, to authorize the Director of Motor Vehicles to adopt rules and regulations; and to provide for inspections. *APPROVED*

S-464—To repeal an act imposing an excise tax upon the gross receipts of unincorporated businesses approved June 17, 1966. *APPROVED*

S-475—To provide immunity from liability to registered members of the National Ski Patrol System where emergency first-aid and rescue services are performed. *APPROVED*

A-292—To provide for physical fitness re-examination of motor vehicle licensees at least once every three years. *DISAPPROVED* . . . because the measure is unclear as to its content and impractical in terms of fulfillment.

At its preceding meeting, the Council deferred action on A-292 pending study and recommendation by the special committee on Traffic

Safety. At its meeting on March 29, the committee on Traffic Safety studied this measure in detail with a representative from the Division of Motor Vehicles. It was generally noted by the special committee that A-292 was not supported by the Division of Motor Vehicles or the Administration. The bill as drawn is unclear as to its exact or specific intent. The special committee recommended the position noted above and adopted by the Council.

A-600—To expand mental health services. *APPROVED*

A-607—To provide that information to the State Board of Medical Examiners by applicants for examination shall include a declared intention to become a citizen of the United States. *APPROVED*

At its preceding meeting, the Council deferred action on A-607 pending study and report by the special committee of the Board of Trustees.

A special committee of the Board of Trustees met with representatives of the State Board of Medical Examiners to discuss this measure. The conferees were unanimous in supporting the intent of A-607. However, they felt that A-607 should be amended to include a provision which would require surrender of a license if, at the end of six years, the declaration of intent had not resulted in the attainment of citizenship. In proposing the draft submitted by the Council on Legislation, the Legislative Analyst had given assurance that this provision had already existed in current statute. Subsequently, Legal Counsel to the Society supported this position. The Board was unanimous in its approval of A-607. The Council sustained this position of the Board.

A-666—To authorize a governing body to prescribe penalties for violation of air pollution control ordinances but not in excess of those prescribed in Chapter 212, Laws of 1954, Section 19. *APPROVED*

A-677—To create a clean water council of 17 members in the State Department of Health. *APPROVED*

A-705—To provide for various exemptions under the New Jersey "Sales and Use Tax Act." (Law, Chapter 25) *APPROVED*

A-710—To provide that no person shall deliver potable water to any consumer which does not conform to the standards for potable water of the State Department of Health as established by regulation. *APPROVED*

A-731—To provide for appointments to the State Board of Examiners of Nurses. *DISAPPROVED* . . . because professionally unqualified lay members would encumber the Board with no appreciable advantage to the public.

A-751—To define trademark and the counterfeiting thereof concerning drugs, cosmetics, and devices; to place enforcement in the Department of Health. *ACTION DEFERRED* . . . pending investigation of an amendment to the measure.

A-783—To define "local board of health;" to authorize freeholders to establish, after public hearing, a county board of health by resolution and to provide for appointment of persons thereto. *APPROVED*

A-785—To create the Division of State Medical Examination in the Department of Law and Public Safety; to establish the office of county medical examiner and to abolish the county offices of coroners, county physicians, and chief medical examiners. *APPROVED*

The Legislative Analyst presented a detailed comparative analysis of S-19 and A-785. He also presented a comparative analysis of the proposal submitted to the Attorney General by MSNJ for a State wide Medical Examiners' System and the provisions of A-785.

The Council also considered official communications from the New Jersey Society of Pathologists and the Monmouth County Medical Society, recording their opposition to A-785. The Legislative Analyst reviewd and weighed with the Council the objections enumerated by these two groups.

The Council requested the Legislative Analyst, in its behalf, to reply to the New Jersey Society of Pathologists and the Monmouth County Medical Society, setting forth the questions and answers considered before the Council.

It was the opinion of the Council that — even though A-785 did not contain all the provisions requested by MSNJ — the Administration-sponsored measure was a compromise that was more acceptable than the present plan of county coroner. Dr. Abrams reported that Burlington County Medical Society — the original sponsors of a resolution in the House of Delegates calling for a Statewide Medical Examiners' System — seemed satisfied that this measure was a step in the right direction.

In view of all of the foregoing, the Council recommended approval of A-785.

A-794—To prohibit use of personality tests and psychological investigations in connection with public employment, renewal of a driver's license, or with an application for automobile liability or other insurance. *NO ACTION*

A-811—To provide that ear piercing shall be construed as the practice of medicine and surgery. *ACTION DEFERRED* . . . pending investigation and report.

The Council concluded that the language of A-811 was such — and the bill so drawn — as to warrant clarification. This bill was sponsored at the request of the Morris County Medical Society.

The Council requested that the Executive Director get in touch with representatives of the Morris County Medical Society to explain the Council's position in this matter. It deferred action — pending investigation and report by the Executive Director.

A-853—To provide for reimbursement for services performed by a licensed practicing psychologist for a person covered by a group accident, group health, and a group accident and health insurance policy. *DISAPPROVED,* as unneces-

sary. The psychologist is already entitled to payment for services rendered under any insurance policy which covers the services of a psychologist.

A-854—To provide for reimbursement for services performed by a licensed practicing psychologist for a person covered by any policy of accident and sickness insurance. *DISAPPROVED,* as unnecessary. The psychologist is already entitled to payment for services rendered under any insurance policy which covers the services of a psychologist.

A-856—To provide for reimbursement for services performed by a licensed practicing psychologist for a person covered under a medical service plan. (*ACTIVE OPPOSITION* under emergency provision)

ACTIVE OPPOSITION. The services which psychologists are licensed to provide are not among the services covered by medical service corporations. Psychologists are not licensed or recognized as physicians. They are not qualified or licensed to supply medical or surgical services in treatment of injuries and/or disease conditions—the professional services compensable under coverages supplied by medical service corporations.

Dr. Weinberg reported that the New Jersey Neuropsychiatric Association supported the position of the Council on A-853, A-854, and A-856. These three measures were introduced and advanced so quickly that it was necessary — under emergency provision — for a position of active opposition on A-856 to be taken and an action bulletin sent out on April 28. The Council sustained this position.

A-894—To provide for the development of a program of medical and dental education through establishment of a medical and dental college of South Jersey. *APPROVED*

A-901—To authorize Boards of Freeholders to establish programs of education in narcotics law enforcement and control to be administered by county prosecutors. *APPROVED*

A-910—To provide for the appointment of a five-member "chiropractic committee" to regulate the ethical practice of chiropractic and impose sanctions against unprofessional and unethical conduct. *DISAPPROVED, WITH ACTIVE OPPOSITION IF BILL MOVES.* Present licensing of chiropractors under direction and control of the State Board of Medical Examiners is preferable in the public interest. This legislation attempts to identify the chiropractor as a "physician," a title to which he has no claim on the basis of training or licensure.

. . . Considered the following bills and approved the recommendation of the Council on Leigslation that they be noted and filed as not being of concern at this time:

S-308—To provide that the waiver of consent to marriage of a minor applicable to a parent or guardian must be approved by a judge of the County Court or the Juvenile and Domestic Relations Court; to provide that consent shall not be required where the parent or guardian are deceased, have abandoned the minor, are committed to an institution for persons of unsound mind, or where custody has been awarded to the other parent.

A-645—To consider as exempt organizations under the "Sales and Use Tax Act" any non-profit volunteer fire company, volunteer first aid, ambulance, rescue or emergency squad, or affiliated auxiliary or brotherhood society.

A-745—To provide for major medical and health insurances for county and municipal employees; to further amend the act concerning such employees' group insurance programs in several respects.

A-749—To change the name of the Division of Animal Industry to the Division of Animal Health.

A-779—To permit municipalities to enter contractual relationships with existing or private facilities to provide aftercare treatment for individuals released from mental hospitals.

A-809—To provide that the State Commissioner of Health may waive the minimum population requirement under the act providing a program of state aid to local health agencies where the local health agency was carried on a full time program, beginning July 1, 1966 in place of January 1, 1960.

A-876—To provide for state aid in the amount of 50% of the costs of administering old age assistance, medical assistance to the aged, aid to the disabled, and aid for dependent children programs in addition to other funds provided for such programs.

A-903—To provide that the annual reimbursement grants from federal and state funds for all community health projects in any one county shall not exceed an amount equal to 50¢ for all first class counties and 25¢ for all other counties per capita.

Board of Medical Examiners . . . Nominated the following candidates for the Board of Medical Examiners for submission to the Governor, listed in the order of preference:

Incumbent — Jerome G. Kaufman, M.D., Maplewood
Candidates — 1. Jerome G. Kaufman, M.D., Maplewood
2. John J. Bedrick, M.D., Bayonne
3. Irving R. Hayman, M.D., Paterson

Incumbent — Thomas C. DeCecio, M.D., Cliffside Park
Candidates — 1. Thomas C. DeCecio, M.D., Cliffside Park
2. Donald W. Bowne, M.D., Wanamassa
3. Samuel J. Lloyd, M.D., Trenton

Acting Secretary . . . Appointed Dr. Emanuel M. Satulsky of Elizabeth to serve as "Acting Secretary" of MSNJ for the duration of the Annual Meeting, in view of the illness of Dr. Marcus H. Greifinger, necessitating his absence from the convention.

Resignation of 11th Trustee . . . Accepted with regret the resignation of Dr. Andrew C. Ruoff, III, who is transferring his medical activities to Salt Lake City, Utah.

MSP Coverage for National Accounts . . . Voted to support the recommendation in the supplementary report of the Medical-Surgical Plan with reference to the coverage that will involve the payment of "prevailing fees" for national accounts.

Expressions of Appreciation . . . Commended the President and the Chairman of the Board for their efforts during the year.

. . . Expressed its appreciation to retiring members Dr. John J. Bedrick and Dr. Andrew C. Ruoff, III for their efforts during the year.

May 17, 1967

The reorganization meeting of the Board of Trustees, for the administrative year 1967-68 was held in Atlantic City on May 17, 1967.

New Members . . . Welcomed two new members: Dr. Sherman Garrison of Bridgeton, to fill the unexpired term of Dr. Andrew C. Ruoff, resigned; and Dr. Francis J. Benz of Chatham to fill the vacancy created by the elevation of Dr. Satulsky to the office of Second Vice-President.

Chairman — 1967-68 . . . Re-elected Dr. Frank J. Hughes of Gloucester as Chairman of the Board of Trustees for 1967-68.

Secretary — 1967-68 . . . Elected Dr. Louis F. Albright of Spring Lake as Secretary of the Board of Trustees for 1967-68.

Finance and Budget . . . Re-elected Dr. Thomas C. DeCecio of Cliffside Park to succeed himself as a trustee-member of the Committee on Finance and Budget for a three-year term.

. . . Re-elected Dr. David Eckstein to complete the unexpired term of Dr. Samuel J. Lloyd as a member of the Committee on Finance and Budget.

Meeting Schedule for 1967-68 . . . Agreed to continue its precedent of meeting regularly at 10:45 a.m. on the third Sunday of each month in the Executive Offices.

Salaried Personnel . . . Reappointed for 1967-68, at the salaries set forth in the adopted budget for 1967-68, all salaried personnel not under individual contract.

AMA 1967 Annual Meeting . . . Confirmed authorization of the following to attend the June 1967 Annual Meeting of the AMA (Atlantic City, June 18-22), with expenses paid: President, President-Elect, Executive Director, seven regular delegates, three alternate delegates (Drs. Boylan, Jehl, and Kaufman).

Referrals From 1967 House of Delegates . . . Received and noted the following Resolution (#20-Restriction of Members on Councils/Committees)

RESOLVED, that the House of Delegates go on record as opposing the granting of multiple elective and/or appointive positions to any one member, and urges that hereafter this principle be observed.

. . . Referred the follow Resolution (#24-Blood Insurance Program) to the AMA Delegates, for introduction of an appropriate resolution at the AMA June meeting:

RESOLVED, that MSNJ urge all such groups to insure their blood needs by a blood insurance program rather than through a financial insurance benefit; and be it further

RESOLVED, that the delegates of MSNJ submit this resolution for similar action by the House of Delegates of the American Medical Association.

. . . Referred the following Resolution (#19-Blood Bank Credits Under Blue Cross) to the attention of Hospital Service Plan of New Jersey.

RESOLVED, that MSNJ hereby urge the Hospital Service Plan of New Jersey and the New Jersey Hospital Association to consider a plan wherein all its subscribers may have an option under their present Blue Cross plan, as follows:

If the subscriber chooses to deposit one unit of blood annually, he and his Blue Cross dependents shall be entitled to receive all of the blood or blood derivatives he or his dependents should need, with no charge for the blood or processing cost of said blood; and that, further, a plan will be devised for members of Blue Cross groups to make deposits of blood based on a yet to be determined percentage of the membership of the group, participants of such a plan and all family dependents covered under the contract, will be eligible for the above stated benefits

. . . Directed that a copy of the following Resolution (#23-Medical-Dental School for South Jersey) be sent to the Governor and members of the Senate and Assembly at the appropriate time; and empowered the President to appoint a committee to work with the legislature in implementing such legislation:

RESOLVED, that the House of Delegates of MSNJ recognize the need for a third medical and dental school and that it be located in Southern New Jersey; and be it further

RESOLVED, that the House of Delegates instruct the Board of Trustees to use its good office to urge the Governor and the Legislature to establish a third School of Medicine and Dentistry and locate it in Southern New Jersey; and be it further

RESOLVED, that a copy of this resolution be sent to the Governor and members of the Senate and Assembly of the State of New Jersey

. . . Referred the following substitute Resolution (for #7-Chiropractic As An Unscientific Cult, and #8-Medical Ancillary Personnel) to the President, with the suggestion that a law clerk be engaged to assist the committee in this review:

RESOLVED, that a committee be appointed by the President of MSNJ to review all statutes related to the practice of medicine and surgery in this State and to submit specific recommendations for their revision to the Board of Trustees as quickly as possible.

(The President subsequently appointed the following committee: Dr. Bertha, Chairman; Drs. Lloyd and DeCecio; and Ex-Officio, the Executive Director, Legal Counsel, and Legislative Analyst.)

. . . Referred the following substitute Resolution (for #22-Prohibition of Advertisements and Solicitation by Practitioners of the Healing Arts) to the Council on Legislation for implementation:

RESOLVED, that MSNJ draft appropriate legislation prohibiting such advertising; and in cooperation with other groups of practitioners, arrange for the introduction of such legislation.

. . . Directed that a copy of the following substitute resolution (for #25-Seat Belts in Public Conveyances) be sent to the President of the Senate and the Speaker of the Assembly at the appropriate time:

RESOLVED, that MSNJ urge the legislature of the State of New Jersey to pass legislation providing for mandatory installation of seat belts in public conveyances.

. . . Directed that a copy of the following substitute resolution (for #26-Venereal Disease In Minors) be sent to the Governor, the President of the Senate and the Speaker of the Assembly at the appropriate time:

RESOLVED, that MSNJ memorialize the Legislature of the State of New Jersey to pass — and the Governor to approve — legislation empowering physicians to treat minors ill, or suspected of being ill, with venereal disease without first securing parental consent.

. . . Directed that a copy of the following Resolution (#27-Repeal Of Gross Receipts Tax On Unincorporated Business) be sent to the President of the Senate and the Speaker of the Assembly at the appropriate time:

RESOLVED, that the New Jersey Legislature be urged to repeal Chapter 137, P.L. 1966.

. . . Referred the following resolution (#10-Retention of Provision Under Part B Medicare Excluding Payments of Interns and Residents) to the AMA Delegates, for introduction of an appropriate resolution at the AMA Annual Meeting in June:

RESOLVED, that MSNJ reaffirm its support of the principle presently embodied in the Medicare Law (Title 18) of payment for the costs of medical services to fully licensed physicians freely chosen by the beneficiaries, and of exclusion of payments under Part B to interns and residents; and be it further

RESOLVED, that this resolution be submitted to the House of Delegates of the American Medical Association and that our AMA Delegates do all in their power to obtain its adoption at the national level.

. . . Referred the following resolution (#9-Generic Versus Proprietary Drugs) to the AMA Delegates, for introduction of an appropriate resolution at the AMA Annual Meeting in June:

RESOLVED, that the treating physician should have the choice (in all private paid, insurance paid, and government paid programs) of deciding whether or not

to prescribe generically or by brand-name; and be it further

RESOLVED, that MSNJ support the policy of freedom of choice of drugs by the physician in order to enable him to best serve his patients; and be it further

RESOLVED, that this resolution be submitted to the House of Delegates of the American Medical Association and that our New Jersey Delegates to the American Medical Association do all in their power to obtain its adoption at the national level.

. . . Referred the following resolution (#12-Utilization Review Committee Immunity) to the Council on Legislation:

RESOLVED, that MSNJ be urged to seek the passage of legislation which would provide a physician who serves on any utilization review committee immunity from litigation arising from the actions of the committee.

. . . Directed that a copy of the following resolution (#18- Insurance Coverage for State-Subsidized Patients) be called to the attention of the appropriate official in the State Department of Institutions and Agencies; and referred to the Council on Medical Services:

RESOLVED, that MSNJ actively urge the various agencies involved in the medical care of patients who need financial aid from public funds to procure medical insurance plans for said patients, as well as the hospital insurance plans now provided.

. . . Referred the following recommendation (Amblyopia Detection Program) from the Reference Committee to the Special Committee on Conservation of Vision for implementation:

That this section of the annual report [of the Committee on Conservation of Vision] be approved, with the stipulation that MSNJ retain an authoritative voice in the direction and control of these screening programs.

(The New Jersey Commission for the Blind is to be requested not to make any broad changes in the program without giving advance notice to MSNJ.)

. . . Directed that the following resolution (#13-Community Mental Health Centers) be referred to the Council on Mental Health.

RESOLVED, that each general hospital be encouraged to provide specific in-patient facilities for treatment of acutely mentally ill patients, whether the onset of the patients' overt "mental" illnesses occur in the course of their hospital treatment for "somatic" illness, or occur while they are in the community; and be it further

RESOLVED, that a general hospital should be the nucleus of a Community Mental Health Center.

ODMC Contracts for 1967-68 . . . Empowered the President and the Secretary of the Society to sign the appropriate forms for renewal of the ODMC contracts for 1967-68.

Carrier Clinic Symposium . . . Approved co-sponsorship of the Carrier Clinic's Annual Symposium on "Psychiatry for the Physician," to be held on November 8, 1967 at the Robert Treat Hotel in Newark.

Staff Commendation . . . Unanimously commended the MSNJ staff and the Annual Meeting Committee for an outstanding meeting.

Convention Format . . . Directed that the desirability of rearranging some activities of the convention to avoid conflicting sessions be discussed in detail by the Annual Meeting Committee, requested that alternatives of action be recommended to the Board sufficiently in advance of the 1968 annual meeting.

Haddon Hall . . . Directed that MSNJ's appreciation and commendation be extended to the staff of Haddon Hall for its improvement in facilities and services.

Eye Mobile . . . Authorized the inclusion of MSNJ's name on the outside of the eye mobile screening van which will be used by the New Jersey College of Medicine and Dentistry in implementing the program which has the official approval of this Society.

June 25, 1967

A regular meeting of the Board of Trustees was held on Sunday, June 25, 1967, at the Executive Offices. For further information, detailed minutes are on file with the Secretary of your component society. A summary of the significant actions follows:

AMA Communications Institute . . . Author-

ized attendance of the President and President-Elect as official representatives to the 1967 AMA Communications Institute, with expenses paid.

Conference Committee with JEMPAC . . . Authorized the establishment of a conference committee with JEMPAC (Jersey Medical Political Action Committee) and, for this purpose, designated the following: Chairmen of Councils on Legislation and Medical Services and the Second Vice-President.

AMA Conference on Physicians and Schools . . . Designated the Chairman of the Committee on Child Heath as MSNJ's representative to the AMA Conference on Physicians and Schools (with expenses paid) to be held October 4 to 7 in Chicago.

AMA Conference on Nursing . . . Designated the Chairman of the Committee on Nursing Education and Recruitment as MSNJ's representative to the AMA Conference on Nursing (with expenses paid) to be held October 6 in Chicago.

Increase in Fees for State Disability Examinations . . . Directed that the Society's appreciation for the increase in fee (from $7.50 to $15), effective July 1, 1967, for impartial medical examinations made under the state's disability insurance program, be transmitted to the Division of Employment Security.

Diploma Schools of Nursing . . . Endorsed as the policy position of MSNJ the following resolution as adopted by the AMA:

Whereas, the American Medical Association is on record to "continue its support of *all* current nationally approved educational programs for nurses;" and

Whereas, the national trend which is supported by the professional nurses' associations appears to be the gradual phasing out of the diploma schools of nursing and the transfer of nursing education to collegiate intitutions; and

Whereas, 70 per cent of nursing care at the present time is rendered by graduates of diploma schools, with the demand for such nurses continuing to exceed the supply; and

Whereas, there is general professional agreement on the need for inclusion of nursing education in community health planning with provision for greater use of in-hospital training as well as training in collegiate institutions; therefore be it

RESOLVED, that the American Medical Association reaffirms its support of all forms of nursing education including baccalaureate, diploma, associate, and practical nurse education programs; and be it further

RESOLVED, that those hospitals that conduct diploma schools of nursing be commended for the great contribution being made by these institutions to the health needs of the nation; and be it further

RESOLVED, that such hospitals be urged to continue their schools and increase enrollment while allowing the individual to choose the kind of nursing education he or she desires; and be it further

RESOLVED, that the American Medical Association take appropriate action in consultation with professional nurses' associations and the American Hospital Association to encourage increasing enrollment in diploma schools and at the same time improve educational standards.

The Healing Art . . . Authorized acceptance of the New Jersey State Library's cooperation in giving the Society's Bicentennial History the widest distribution possible as follows:

1. To accept the offer of the State Library to make a mailing in September to a selected list of 3,500;

2. To waive the "cash and carry" policy and to honor vouchers and/or statements; and

3. To run off approximately 3,500 copies of a revised brochure, at a cost to MSNJ of approximately $20.

. . . Authorized extension of the special price of $8.50 to those component societies which desire to distribute copies through their jurisdictions.

Future Annual Meetings . . . Approved the recommendations of the Annual Meeting Committee that Saturday to Wednesday, May 15 to 19, 1971 at Haddon Hall, be reserved for the 205th Annual Meeting of MSNJ; and that the Ocean County Medical Society be informed (in response to its suggestion that Lakewood be considered as a future meeting place) that no change in convention city is contemplated.

Section on Physical Medicine and Rehabilitation . . . Approved the recommendation of the Annual Meeting Committee that the New Jersey Society of Physical Medicine and Rehabilitation be informed that it is too small a group to warrant the formation of a scientific section.

1968 Annual Meeting . . . Approved the following recommended schedule for the 1968 Annual Meeting:

Friday, May 17, 1968
4:00 p.m. — Board of Trustees
7:00 p.m. — Cocktails and Buffet Dinner

Saturady, May 18, 1968
10:00 a.m. — Registration Opens
1:00 p.m. — Golden Merit Award Ceremony followed by Reception for GMA Recipients and their families
3:00 p.m. — House of Delegates and President's Farewell Address
4:30 p.m. — Nominating Committee
7:00 p.m. — Officers' Dinner

Sunday, May 19, 1968
9:00 a.m. — Registration Opens
9:30 a.m. — Special Scientific Sessions
10:00 a.m. — Coffee-meeting with Reference Committee Chairmen
10:45 a.m. — Reference Committees
12:00 noon — Exhibits Open
3:15 p.m. — House of Delegates (election)
4:00 p.m. — Inauguration of Incoming President followed by General Session
6:00 p.m. — Inaugural Reception
8:00 p.m. — Inaugural Dinner

Monday, May 20, 1968
9:00 a.m. — Registration and Exhibits Open
All day — Scientific Sessions (MSNJ)
7:00 p.m. — Annual Dinner-Dance

Tuesday, May 21, 1968
9:00 a.m. — Registration and Exhibits Open
9:30 a.m. — House of Delegates
2:00 p.m. — Scientific Sessions (MSNJ)
7:00 p.m. — Exhibitors' Reception-Buffet Dinner

Wednesday, May 22, 1968
9:00 a.m. — Registration and Exhibits Open
9:00 a.m. — Board of Trustees
9:30 a.m. — Scientific Sessions (MSNJ/Special)
12:00 noon — Exhibits and Convention Close

House of Delegates' Sessions . . . Approved the recommendation that the new addition to the Exhibit Hall at Haddon Hall be utilized for all three sessions of the House of Delegates.

Scientific Sessions . . . Approved the following recommended schedule for the 1968 Scientific Sessions:

Monday morning, May 20, 1968
Joint Session on Obstetrics and Gynecology, Urology
Joint Session on Allergy, Otolaryngology, Pediatrics
Joint Session on Anesthesiology, Gastroenterology and Proctology, General Practice
Joint Session on Clinical Pathology, Metabolism
Joint Session on Orthopedic Surgery, with the New Jersey Orthopaedic Society

Monday afternoon, May 20, 1968
Session on Chest Diseases
Session on Surgery (possibly with Radiology)
Session on Rheumatism (possibly with Radiology)
Session on Psychiatry and Neurology

Tuesday afternoon, May 21, 1968
Joint Session on Cardiovascular Diseases, Medicine
Joint Session on Dermatology, with the Industrial Medical Association of New Jersey
Session on Ophthalmology
Session on Plastic and Reconstructive Surgery

Wednesday morning, May 22, 1968
Clinical Pathological Conference

Attendance Awards (Commercial Exhibits) . . . Approved the recommendation that a physician's attendance award be inaugurated with the 1968 Annual Meeting, in an effort to increase attendance at the commercial exhibits.

Inauguration Ceremonies . . . Approved the proposal that presidents of component societies be invited to take part in the inauguration ceremonies of the incoming president.

AMA Annual Meeting . . . Approved the following temporary report of the AMA Delegates:

All four resolutions proposed by MSNJ were acted upon favorably — two, in opposition to recommendations of the reference committee. They were as follows:

1. *Resolution #37 — Generic vs. Proprietary Drugs* . . . Four related resolutions (#37, #66, #84, and #87) were introduced. A substitute resolution embodying all four was adopted.

2. *Resolution #38 — Blood Insurance Program* . . . A committee substitute, as amended, was adopted.

3. *Resolution #97 — Model Partnership Agreement and Model Articles of Incorporation Presented as Appendix 1 and 2 to Report C of the Council on Medical Service* . . . This resolution was adopted against the recommendation of Reference Committee "D" and referred to the Council on Medical Service, with the stipulation that no further circulation was to be made until the matter was again considered in Houston at the Clinical Meeting.

4. *Resolution #98 — Retention of Provision Under Part B of Medicare Excluding Payment of Interns and Resident* . . . The resolution was adopted against the recommendation of Reference Committee "A."

Widows and Orphans Society . . . Reaffirmed its support of the Widows and Orphans Society and made the following suggestions to

the President of that Society for recruiting new members:

1. Continue submission of material for publication in *The Journal.*

2. Request the Woman's Auxiliary to establish at local level committees on Widows and Orphans of Medical Men and solicit their support in an active campaign to get new members.

3. Consider inclusion of an additional page in MSNJ's *Membership Directory,* outlining all the details of the society.

4. Request component societies to mail the Widows and Orphans brochure with county bulletins or billings.

5. Ask component societies to schedule speakers at meetings to outline the program and solicit new members.

Board of Medical Examiners . . . Nominated the following in order of preference for consideration at the expiration of the term of Dr. Edwin H. Albano on the Board of Medical Examiners: Edwin H. Albano, M.D., East Orange; Sherman Garrison, M.D., Bridgeton; and Joseph M. Gannon, M.D., Plainfield.

New Jersey Public Health Association . . . Agreed to cosponsor the fall conference of the New Jersey Public Health Association, September 27 at the Far Hills Inn, Somerville.

MSNJ Woman's Auxiliary . . . Approved the following actions of the Woman's Auxiliary Board:

(a) *Vietnamese Student Aid Project* . . . voted to give financial aid to the project in the amount of $25 and to urge its county auxiliaries also to contribute to the project.

(b) *Volunteer Friendly Visitors* . . . voted to appoint a liaison representative to the State Committee on Volunteer Friendly Visitors — sponsored by the New Jersey State Department of Health.

Heart Disease, Cancer, and Stroke . . . Accepted the report of the Chairman of the Board of Trustees of the New Jersey Joint Committee For Implementation of P.L. 89-239 (Dr. Jehl) that the revised application for a planning grant for a New Jersey program had been approved in the amount of $600,000. The New Jersey College of Medicine and Dentistry will be the fiscal agent for the expenditure of this money.

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

(Listed in order of receipt)

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

INTERNAL MEDICINE — Ronald G. MacClary, M.D., 6 Granada Terrace, Middletown, Rhode Island 02840. University of Michigan, 1958. Board eligible. Group. Available August 1967.

Jerome E. Block, M.D., 1601 Greycastle Avenue, Montebello, California. New Jersey College of Medicine, 1964. Solo or associate. Small town. Available July 1968.

OBSTETRICS AND GYNECOLOGY — David M. Margulies, M.D. 69 Euclid Road, Fort Lee, New Jersey. Northwestern University Medical School, 1961. Board certified. Available.

Arthur G. Aneckstein, M.D., 104A Jupiter Street, Sheppard AFB, Texas 76311. Tulane, 1961. Board eligible. Solo, partnership, or association. Available February 1968.

OPHTHALMOLOGY—M. Farooq Anwar, M.D., University Hospital, Birmingham, Alabama 35233. King Edward Medical College, Pakistan, 1960. Full time hospital staff. Available.

PATHOLOGY—Melvin Stahl, M.D., 27 Bradford Road, Natick, Massachusetts 01760. Boston University School of Medicine, 1956. Solo or associate in community hospital. Available November 1967.

PEDIATRICS—Nathan Blinn, M.D., 1514 East Cliveden Street, Philadelphia, Pennsylvania. Jefferson Medical College, 1963. Solo or group. Available July 1968.

SURGERY — Lawrence B. Langsam, M.D. 1707 Terry Avenue, Bellevue, Nebraska 68005. Downstate Medical Center, 1960. Board certified. Group or partnership. Available August 1967.

A. Allen Badri, M.D., 6315 North Rosebury, Clayton, Missouri 63105. University of Teheran Medical School, 1959. General and plastic. Available.

James M. York, M.D., 741 Mt. Vernon Avenue, Marion, Ohio 43302. Johns Hopkins, 1956. Orthopedic. Available.

1967-1968

Committees and Councils

AMA Delegates

C. Byron Blaisdell, M.D. (1968) Asbury Park
Joseph P. Donnelly, M.D. (1969) Jersey City
Marcus H. Greifinger, M.D. (1968) Newark
Frank J. Hughes, M.D. (1968) Gloucester
Jesse McCall, M.D. (1969) Newton
Luke A. Mulligan, M.D. (1968) Leonia
Isaac N. Patterson, M.D. (1969) Westville

AMA Alternate Delegates

Matthew E. Boylan, M.D. (1968) Jersey City
John J. Bedrick, M.D. (1968) Bayonne
Jerome G. Kaufman, M.D. (1968) Maplewood
John F. Kustrup, M.D. (1968) Trenton
Joseph R. Jehl, M.D. (1969) Clifton
Robert E. Verdon, M.D. (1969) Cliffside Park
Louis S. Wegryn, M.D. (1969) Elizabeth

Delegates to Other States Delegates

New York—Joseph P. Donnelly, M.D. (1968)
Jersey City
Connecticut—Lloyd A. Hamilton, M.D. (1968)
Lambertville

Alternates

New York—John W. Holland, M.D. (1968) .. Margate
Connecticut—Frank W. Konzelmann, M.D. (1968)
Somers Point

STANDING COMMITTEES

Annual Meeting

Jerome G. Kaufman, M.D., *Chairman*
(1968) Maplewood
Edward E. P. Seidmon, M.D., *Vice-Chairman*
(1970) Plainfield
Milton Ackerman, M.D. (1969) Atlantic City
Peter H. Marvel, M.D. (1970) Northfield
James A. Rogers, M.D. (1968) Paterson
Robert E. Verdon, M.D. (1969) Cliffside Park
Marcus H. Greifinger, M.D., *Secretary*
Ex-Officio Newark

*Scientific Exhibits

Milton Ackerman, M.D., *Chairman* (1968) Atlantic City
Arthur Bernstein, M.D. (1968) Maplewood
Sidney S. Girsh, M.D. (1968) Atlantic City
Thomas K. Rathmell, M.D. (1968) Trenton
John J. Thompson, M.D. (1968) Caldwell
Robert E. Verdon, M.D. (1968) Cliffside Park

*Scientific Program

James A. Rogers, M.D., *Chairman* (1968) Paterson

* Subcommittee of Annual Meeting Committee.

Allergy

William B. Greenberg, M.D., *Chairman* . Perth Amboy
Edward Pickert, M.D., *Secretary* Irvington

Anesthesiology

Dexter B. Blake, M.D., *Chairman* Morristown
Thomas C. Wickenden, M.D., *Secretary* ... Short Hills

Cardiovosculor Diseoses

Theodore H. Goldberg, M.D., *Chairman* ... Westwood
William M. Burke, M.D., *Secretary* Jersey City

Chest Diseoses

Raymond E. Miller, M.D., *Chairman* Trenton
James R. Johnson, M.D., *Secretary* Jersey City

Clinicol Pothology

Simon Soumerai, M.D., *Chairman* Camden
Gerald S. Eichner, M.D., *Secretary* Bridgeton

Dermotology

Harry C. Goldberg, M.D., *Chairman* Plainfield
Irwin L. Maskin, M.D., *Secretary* Fairlawn

Gostroenterology and Proctology

Salvatore J. Detrano, M.D., *Chairman* Union City
Louis A. Brodkin, M.D., *Secretary* Irvington

Generol Proctice

Carl A. Restivo, M.D., *Chairman* Jersey City
William L. Sprout, M.D., *Secretary* Salem

Medicine

Jacob L. Drossner, M.D., *Chairman* Pennsauken
Howard A. Levy, M.D., *Secretary* Collingswood

Metobolism

Pauline R. Goger, M.D., *Chairman* Flemington
Arthur Krosnick, M.D., *Secretary* Trenton

Obstetrics and Gynecology

Paul S. Andreson, M.D., *Chairman* Elizabeth
Herik R. Caterini, M.D., *Secretary* Newark

Ophtholmology

Humbert M. Gambacorta, M.D., *Chairman* .. Newark
Samuel B. Pole, M.D., *Secretary* Bridgeton

Orthopedic Surgery

John J. Reilly, Jr., M.D., *Chairman* Elizabeth
John C. Roy, M.D., *Secretary* Morristown

Otoloryngology

James E. Brennan, M.D., *Chairman* Camden
F. Robert Haase, M.D., *Secretary* Neptune City

Pediotrics

Louis L. Krafchik, M.D., *Chairman* .. New Brunswick
Alvin R. Mintz, M.D., *Secretary* Morristown

Plostic ond Reconstructive Surgery

Merton L. Griswold, Jr., M.D., *Chairman* .. Plainfield
Vincent J. Bagli, M.D., *Secretary* Fairlawn

Psychiotry ond Neurology

Joseph C. Borrus, M.D., *Chairman* ... New Brunswick
Avrohn Jacobson, M.D., *Secretary* Asbury Park

Radiology

John R. Helff, M.D., *Chairman* New Brunswick
Richard Kirchner, M.D., *Secretary* ... New Brunswick

Rheumatism

William D. Kimler, M.D., *Chairman* Collingswood
James W. Robinson, M.D., *Secretary* Summit

Surgery

Stephen H. M. Plum, M.D., *Chairman* Morristown
Warren H. Knauer, M.D., *Secretary* Hillside

Urology

Harold B. Schwartz, M.D., *Chairman* Union City
Bernard D. Pinck, M.D., *Secretary* Passaic

Credentials

Marcus H. Greifinger, M.D., *Chairman* (Secretary) Newark
Eugene J. Tyrrell, M.D., *Vice-Chairman* (1970) Perth Amboy
William E. Bray, M.D. (1970) Pemberton
S. Thomas Camp, M.D. (1969) Westville
Charles P. Campbell, M.D. (1968) Hackensack
Elton W. Lance, M.D. (1968) Rahway
Raymond A. McCormack, M.D. (1969) Trenton

Finance and Budget

Thomas C. DeCecio, M.D., *Chairman* (1970) Cliffside Park
Theodore K. Graham, M.D., *Vice-Chairman* (1969) Paterson
Charles A. Landshof, M.D. (1968) Jersey City
David Eckstein, M.D. (1969) Trenton
Nicholas E. Marchione, M.D. (1968) Vineland
John S. Van Mater, M.D. (1970) New Brunswick
Samuel J. Lloyd, M.D., *Treasurer* Ex-Officio Trenton

Honorary Membership

Ralph M. L. Buchanan, M.D., *Chairman* (1970) Phillipsburg
Spencer T. Snedecor, M.D., *Vice-Chairman* (1969) Hackensack
David B. Allman, M.D. (1968) Atlantic City

Medical Defense And Insurance

Fred A. Mettler, M.D., *Chairman* (1969) .. Blairstown
Ernest C. Hillman, Jr., M.D., *Vice-Chairman* (1969) Newark
William D'Elia, M.D. (1970) Neptune City
Elton W. Lance, M.D. (1968) Rahway
Jesse Schulman, M.D. (1968) Lakewood
Benjamin F. Slobodien, M.D. (1970) Perth Amboy
Marcus H. Greifinger, M.D., *Secretary* Ex-Officio Newark

Medical Education

Sherman Garrison, M.D., *Chairman* (1968) ..Bridgeton
Louis F. Albright, M.D. (1969) Spring Lake
Frank S. Forte, M.D. (1968) Newark
John W. Nicholson, III, M.D. (1970) Moorestown
Morris H. Saffron, M.D. (1970) Passaic
William T. Snagg, M.D. (1969) Camden

Student Loan Fund

Luke A. Mulligan, M.D., *Chairman* (1968) Leonia
Frank J. Hughes, M.D., *Vice-Chairman* (1968) Gloucester
Nicholas A. Bertha, M.D. (1969) Wharton
Charles H. Calvin, M.D. (1970) Perth Amboy
John F. Kustrup, M.D. (1970) Trenton

Publication

George B. Sharbaugh, M.D., *Chairman* (1969) Trenton
C. Spencer Davison, M.D. (1970) Salem
James J. Fitzpatrick, M.D. (1968) Trenton
John F. Kustrup, M.D., *President-Elect* Ex-Officio Trenton
Marcus H. Greifinger, M.D., *Secretary* Ex-Officio Newark
Henry A. Davidson, M.D., *Editor* Ex-Officio Cedar Grove

Revision of Constitution And Bylaws

Louis F. Albright, M.D., *Chairman* (1968) Spring Lake
Joseph M. Gannon, M.D., *Vice-Chairman* (1968) Plainfield
Sherman Garrison, M.D. (1970) Bridgeton
John A. Smith, M.D. (1969) South River
John J. Thompson, M.D. (1969) Caldwell
Robert E. Verdon, M.D. (1970) Cliffside Park
Marcus H. Greifinger, M.D., *Secretary* Ex-Officio Newark

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Edward M. Coe, M.D. (1970) Cranford
Thomas H. McGlade, M.D. (1968) Camden
Volmar A. Mereschak, M.D. (1969) Phillipsburg

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William A. Dwyer, Jr., M.D. (1970) Paterson
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Joseph M. Gannon, M.D. (1970) Plainfield
Charles B. Norton, Jr., M.D. (1969) Woodstown
I. Edward Ornaf, M.D. (1969) Camden
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Mental Health

Robert S. Garber, M.D., *Chairman* (1969) .. Belle Mead
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John R. Rushton, III, M.D. (1970) Camden
Martin H. Weinberg, M.D. (1969) Trenton
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Francesco A. Figurelli, M.D. (Consultant) .. Jersey City
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Public Health

John P. Coughlin, M.D., *Chairman* (1969) .. Jersey City
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Peter J. Guthorn, M.D. (1969) Neptune City
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S. William Kalb, M.D. (1968) Newark
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Adolph Wichman, M.D. (1970) Denville
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Emanuel M. Satulsky, M.D., *2nd Vice-President* Ex-Officio Elizabeth

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Delma W. Caldwell, M.D. (1968) Linden
E. Vernon Davis, M.D. (1968) Mount Holly
William J. D'Elia, M.D. (1968) Spring Lake
Elmer J. Elias, M.D. (1968) Trenton
Lloyd A. Hamilton, M.D. (1968) Lambertville
Dominic A. Kujda, M.D. (1968) Pompton Plains
Carl A. Maxwell, M.D. (1968) Phillipsburg
William D. Van Riper, M.D. (1968) .. New Brunswick
Mathilda R. Vaschak, M.D. (1968) New Brunswick
Ralph A. Young, M.D. (1968) Linden
Joshua N. Zimskind, M.D. (1968) Trenton
Jarvis Smith, M.D. (Consultant) Trenton

SPECIAL COMMITTEES TO THE ADMINISTRATIVE COUNCIL ON PUBLIC HEALTH

Air Pollution Control

Roslyn Barbash, M.D., *Chairman* (1968) Teaneck
James G. Dickensheets, M.D. (1968) Camden
Michael R. Ramundo, M.D. (1968) Passaic
William J. Roe, M.D. (1968) Englewood
Frank L. Rosen, M.D. (1968) Maplewood
Edward E. P. Seidmon, M.D. (1968) Plainfield
Aaron Weiner, M.D. (1968) Fairlawn
William I. Weiss, M.D. (1968) Livingston

Cancer Control

John L. Olpp, M.D., *Chairman* (1968) Englewood
Roy T. Forsberg, M.D., *Vice-Chairman* (1968) Westfield
Harold Colburn, M.D. (1968) Mount Holly
George L. Erdman, M.D. (1968) Summit
Warren H. Knauer, M.D. (1968) Elizabeth
Bernard Koven, M.D. (1968) Englewood
Stephen M. Liana, M.D. (1968) Paterson
Sylvan E. Moolten, M.D. (1968) Highland Park

Child Health

William J. Farley, M.D. *Chairman* (1968) Nutley
William Beall, M.D. (1968) Woodbury
Neil Castaldo, M.D. (1968) Cranford
Robert E. Jennings, M.D. (1968) South Orange
Thomas P. McFarland, Jr., M.D. (1968) .Mays Landing
Bernard N. Millner, M.D. (1968) Trenton
Eli Rubenstein, M.D. (1968) Bayonne
Sydney Tucker, M.D. (1968) Perth Amboy
Charles O. Tyler, M.D. (1968) Haddonfield
Alfred R. Richlan, M.D. (Consultant) Trenton

Conservation Of Vision

Frank B. Vanderbeek, M.D., *Chairman* (1968) Paterson
Henry Abrams, M.D. (1968) Princeton
Alfonse A. Cinotti, M.D. (1968) Jersey City
Samuel M. Diskan, M.D. (1968) Atlantic City
Joseph H. Kler, M.D. (1968) New Brunswick
Oram R. Kline, M.D. (1968) Camden
Robert E. Murto, M.D. (1968) Trenton
Ralph E. Siegel, M.D., (1968) Perth Amboy
Ralph A. Skowron, M.D. (1968) Cherry Hill
D. Blair Sulouff, M.D. (1968) Morristown
Anthony M. Sellitto, M.D. (Consultant) . South Orange

Maternal and Infant Welfare

John D. Preece, M.D., *Chairman* (1968) Trenton
Mary Bacon, M.D. (1968) Bridgeton
Robert A. Cosgrove, M.D. (1968) Jersey City
Frederick J. Faux, M.D. (1968) Woodbury
Edward Foord, M.D. (1968) Burlington
Theodore K. Graham, M.D. (1968) Paterson
Dominic A. Introcaso, M.D. (1968) Clark
Herbert F. Johnson, M.D. (1968) Camden
Arthur C. Kragen, M.D. (1968) East Orange
Frank L. Paret, M.D. (1968) New Brunswick
Daniel B. Roth, M.D. (1968) Teaneck
Francis U. Seiler, M.D. (1968) Trenton
Watson E. Neiman, M.D. (Consultant) Trenton

Emergency Medical Care

Jack R. Karel, M.D., *Chairman* (1968) Hillside
R. Winfield Betts, M.D., *Vice-Chairman* (1968) Medford
Albert Ehrlich, M.D. (1968) Fort Lee
John A. Flood, Jr., M.D. (1968) Trenton
Sidney Ketyer, M.D. (1968) South Orange
Frank L. Paret, M.D. (1968) New Brunswick
Lynn A. Parry, M.D. (1968) Asbury Park
Frank R. Schell, M.D. (1968) Butler
Marie A. Sena, M.D. (Consultant) Linden

Medicine and Religion

Jerome G. Kaufman, M.D., *Chairman* (1968) Maplewood
Charles H. Calvin, M.D. (1968) Perth Amboy
John S. Madara, M.D. (1968) Salem
Thomas H. McGlade, M.D. (1968) Camden
Luke A. Mulligan, M.D. (1968) Leonia

Retirement Plan For Physicians

Nicholas E. Marchione, M.D., *Chairman* (1968) Vineland
Albert F. Moriconi, M.D. (1968) Trenton
[*vacancy* (1968)]
Herbert W. Weisman, M.D. (1968) Bayonne

Traffic Safety

R. Winfield Betts, M.D., *Chairman* (1968) .. Medford
Albert Ehrlich, M.D. (1968) Fort Lee
Martin D. Meyerson, M.D. (1968) Edison
William L. Sprout, M.D. (1968) Salem
Robert S. Garber, M.D. (1968) Belle Mead
Harry F. Suter, M.D. (1968) Penns Grove
Frank B. Vanderbeek, M.D. (1968) Paterson

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Bergen

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Robert E. Verdon, M.D., *Secretary* Cliffside Park
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Jules Cooper, M.D., *Secretary* Woodbine

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Frank J. T. Aitken, M.D., *Secretary* Bridgeton

Essex

Robert C. Anderson, M.D., *President* Newark
[*vacancy*] *Secretary*
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Hudson

Conrad M. Bahnson, M.D., *President* Jersey City
John J. Crosby, Jr., M.D., *Secretary* Jersey City
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John F. Marshall, M.D., *President* Trenton
Robert E. Murto, M.D., *Secretary* Trenton
Mrs. Annette B. Nicholas, *Exec. Secretary* ... Trenton

Middlesex

Charles Gandek, M.D., *President* Nixon
Merle B. Davis, M.D., *Secretary* Highland Park
Miss Carolyn M. Kidd, *Off. Secretary* Fords

Monmouth

Anthony P. DeSpirito, M.D., *President* .. Asbury Park
Frederick C. Steller, M.D., *Secretary* Spring Lake
Mrs. Mary Gorman, *Exec. Secretary* Avon

Morris

Henry O. von Deilen, M.D., *President* Morristown
Seymour F. Kuvin, M.D., *Secretary* Morristown
Mrs. Irma Crum, *Exec. Secretary* Morristown

Ocean

John Kengeter, M.D., *President* Toms River
Stanley Siegler, M.D., *Secretary* Toms River
Mr. John Schaefer, *Exec. Secretary* Jackson

Passaic

Irving Chrisman, M.D., *President* Paterson
Bernard D. Pinck, M.D., *Secretary* Paterson
Mrs. Katherine Cingale, *Exec. Secretary* Paterson

Salem

Samuel P. Reed, M.D., *President* Alloway
Charles G. Young, M.D., *Secretary* Woodstown

Somerset

Arthur W. Culberson, M.D., *President* Somerville
Harold N. Wender, M.D., *Secretary* Bound Brook
Mrs. Betty Menapace, *Exec. Secretary* Somerville

Sussex

Charles L. Ringe, M.D., *President* Blairstown
Douglas A. Hammett, M.D., *Secretary* Sparta

Union

Roy T. Forsberg, M.D., *President* Westfield
Henry J. Mineur, M.D., *Secretary* Elizabeth
Miss Mary Louise Rogers, *Exec. Secretary* .. Elizabeth

Warren

Nathan I. Kantor, M.D., *President* Phillipsburg
Ralph M. L. Buchanan, M.D., *Secretary* . Phillipsburg
Miss Jane Stamets, *Exec. Secretary* Phillipsburg

Opportunities For Disability Medical Examiners

The fee paid physicians for impartial medical examinations made under the state's disability insurance program was increased from $7.50 to $15.00 on July 1.

Edward J. Hall, Director of the Division of Employment Security, the agency which administers the program, said that the change is aimed at making the physician's fee more realistic in terms of today's economy. In addition, Hall said, if the examining physician feels that clinical tests are necessary to his evaluation of the case, the state will also meet the cost of the tests. To obtain approval of such costs, the physician need only telephone the Division's Disability Insurance Service Medical Unit (609-292-2799).

New Jersey's temporary disability insurance program provides cash benefit payments to workers who suffer off-the-job illnesses or disabilities. Workers who are covered by the state's unemployment insurance law are also protected by the disability benefits plan. Although employers may provide disability insurance coverage for their workers through an approved private plan or the State Plan, a majority of the workers are under the State Plan. To obtain State Plan benefits promptly, the worker and physician are urged to mail the claim forms immediately upon onset of disability. This claim includes a medical certification by the attending physician. Physicians may request a supply of forms (DS-1) for their patients. These forms are also available at all Employment Service offices throughout the state.

In most cases, benefit checks are mailed weekly until the claimant is able to return to his regular work. However, where the inability to return to work appears to be unduly prolonged, the Disability Insurance Service may ask for an impartial medical examination. As a matter of fact, the attending physician sometimes indicates a desire for such an examination by drawing two lines under his signature on the additional certification form. Impartial medical examinations are conducted through a cooperative plan in which the state agency and the county medical societies participate. In 1966, some 2100 impartial medical examinations were conducted.

"Since the inception of the disability insurance program in 1948, this agency has been extremely fortunate in that it has enjoyed the fullest cooperation of physicians and their professional organizations," Director Hall said. "We hope this increase in fee will further help our cooperative efforts on behalf of the doctors' patients."

Hall added that any physician who wishes to accept cases under the impartial medical examination program, should call his county medical society.

Eugene J. Ranucci, Chief,
State Plan Disability Benefits Office

All Measles Can Be Prevented

So says the AMA. The Association says that more than two million American youngsters suffered measles during 1966. This still-common disease causes about 500 deaths a year, leaves many of its victims with deafness or mental defects, and triggers secondary diseases such as pneumonia and encephalitis. Yet all of these, adds the AMA, can be prevented through the use of measles vaccines, one of which has been available since the spring of 1963. The same is true of the 300 cases of tetanus, 164 cases of diphtheria and the 72 cases of poliomyelitis which were reported in 1965 by the United States Public Health Service. These three diseases, a year earlier, caused 238 deaths.

The American Medical Association now calls on us as individual physicians to "lead the

battle to eradicate these preventable diseases by conducting intensive local immunization campaigns in cooperation with public health departments, specialty societies, health agencies and health educators."

To encourage such local efforts, the AMA has prepared for you a comprehensive kit of basic communications materials and guidelines to serve as the backbone for whatever type of immunization program you want to develop. Each of these kits contains 25 basic communications tools ranging from a letter to mothers (in pamphlet form) to materials created for use in the mass media. The kit is keyed toward encouraging individuals to obtain immunization from their personal physician. Doctors designated to organize local programs can obtain a kit from the Health Education Department, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Promotion of immunization has been a continuing part of the AMA's health education program. Campaigns aimed at thwarting polio, smallpox, and tetanus were forerunners of the current, broad-based program.

"While the major thrust of the new campaign is aimed at immunization against measles," said Dr. Fred V. Hein, director of the AMA's Health Education Department, "we must not relax our efforts against other diseases preventable by immunization. For not only do we have the means to eradicate measles in the foreseeable future, but also to eliminate the deaths from tetanus that occur each year. We have the means, too, to prevent the outbreaks of diphtheria and poliomyelitis that crop up from time to time, and to bring under better control the other communicable diseases for which we have effective vaccines.'"

Measles is still a universal illness. Some 90 per cent of the adult population in the United States has had measles; but, because of its prevalence, there is general apathy to the disease. Yet its side effects and complications make measles more serious than the general public realizes. An average of one death occurs in every 10,000 cases.

With the licensing of three different measles vaccines in the past four years, some inroads have been made. The number of cases reported to the USPHS (which estimates that only about 10 per cent of the actual number of cases are reported) dropped from 458,083 in 1964 to 202,886 in 1966. The figure was a 21-year low. Dr. H. Bruce Dull, assistant chief of the Communicable Disease Center in Atlanta, estimates that from 18-20 million measles-susceptible children have been vaccinated in the past four years as the result of "excellent performances" by the medical profession and state and local health departments.

Among the concentrated efforts carried out by medical societies last year were a statewide, "End measles once and for all," campaign conducted by the Rhode Island Medical Society, and similar programs conducted by medical societies and other members of the health teams in metropolitan Pittsburgh and Detroit. In the special Rhode Island campaign 34,458 children (66.9 per cent of the measles-susceptible population) were immunized. In Detroit more than 171,000 children were immunized, and in Pittsburgh 52,241.

But, as Dr. Dull points out, only about 45 per cent of susceptible children (ages 1 through 8) have so far been immunized. Still to be protected are the remaining 55 per cent — six million youngsters who will enter kindergarten or grades one and two this year and an estimated four million more who will reach age one during 1967.

Chief objectives of immunization programs urged by the AMA are:

1. Acquaint the public with available immunizations, their values and at what times in life they should be obtained.

2. Encourage people to seek immunization according to recommended schedules.

3. Encourage physicians to step up their efforts to maintain a high level of immunization among their patients.

Early Commitment To Internships And Residencies

The AMA Council on Medical Education, now suggests the following principles:

1. Seeking commitment of medical students (prior to graduation)to residencies in specific specialties is coercive and restrictive of a student's rights.

2. It is the position of the AMA that special commitments on the part of medical students merely reflect the students' intentions at the time they were made, and are neither legally nor ethically enforceable as contracts. Students should assume such training in medical specialties or general practice as is consistent with their personal circumstances and interests. The freedom to chart one's future is as sacred as the physician's freedom to choose his patients or the patient's freedom to choose his doctor.

3. Competition between interns for residency appointments, and the concurrent competition between residency program directors for trainees has resulted in a trend toward residency appointments so early in the intern year that the candidate has no opportunity to select his field of specialty training on the basis of his experience as an intern. It is desirable that those interns who have not already identified their areas of specialty interest be given opportunity for further exploration during at least the first four months of the internship.

4. The Council on Medical Education asks the cooperation of all appropriate specialty groups for the voluntary establishment of a uniform date for appointment of interns to first-year residencies, and that this date be set not earlier than November 15.

5. The significance of the uniform date for appointment of interns to first-year residencies is that the intern is not obligated to accept an appointment, even though it is offered, before the date voluntarily agreed upon by the responsible program directors in each specialty.

6. In developing a method for implementing a program of uniform appointment, interested specialty groups should consider the experience of intern program directors prior to establishment of the NIMP, as well as the experience of the psychiatry program directors prior to development of their own matching program.

7. If the establishment of uniform appointment dates by additional specialty groups results in the creation of additional residency matching plans, the resources of the National Intern Matching Program, Inc. should be explored; reorganization of the NIMP should be considered, to make this effective organization more useful in the area of its special competence, and to eliminate the confusion of multiple, independent matching operations.

8. If additional residency matching programs are developed, the Directory of Approved Internships and Residencies should serve to list the matching code number for residencies just as it now does for internships.

AMA Archive-Library

A young intern, hoping to practice in East Africa wants to correspond with medical people already there. Needing names and addresses, he writes to the American Medical Association Archive-Library for assistance.

A doctor, well established in a practice he has maintained for twenty years, finally gets the opportunity to take his wife on their dream tour of Europe. They will be in Switzerland in July. He wonders if there will be any medical meetings he can attend in Switzerland during their visit. He writes to the Archive-Library for information.

A general practitioner has a patient, a 17-year-old girl, who is planning to attend a year of school in Guatemala. She is a potential surgery patient. He is concerned about the

type and quality of medical service available in the region. He writes to the Archive-Library for help.

The Archive-Library services to members include conducting medical literature searches and compiling bibliographies free of charge. And the Library's photocopy service is also free to you. Any article from any journal to which the Library has access can be copied and sent to you for your files. The Library handles some 1,800 requests, similar to those above for information and publications, from physician members every month. Questions and requests may range from the treatment of chlorine inhalation or statistics on human longevity, to the latest treatment for Scleroderma or Raynaud's Disease, to plans for the mass treatment of large numbers of burned patients.

The AMA Archive-Library upholds the traditional role of the medical library as an adjunct to the postgraduate education of the physician in practice, but it is even more than a library. It is a complete information center. Its collection on the sociology and economics of medicine is the best in the world. It contains almost all the English language publications and includes opinions reflected in mass media as well as in scholarly works.

At the core of the Library is a collection of current medical publications. Today, 2,200 journals are received on a regular basis. This is twice the number contained in any average medical school library. These represent all the major publications in medicine and the allied sciences. In addition to the periodicals, the Library contains 40,000 books. This makes the Archive-Library one of the most complete current medical libraries you will find any place.

Perhaps the one thing above all others which sets the AMA medical Library apart is the availability to the Library staff of a unique resource: the professional staff members of the AMA's 20 scientific departments. "The professional staff is here and we use them," Susan Crawford, director of the Archive-Library, says. "Few other libraries have this type of consultation available. When a doctor writes to us and wants medical opinion or judgment, his question is referred to a consultant on the AMA staff, or to one of many specialists in the country.

The 26 members of the Archive-Library staff will go to great lengths to give you the information you need. They are especially trained to communicate with physicians — they speak your language. Half of the staff have graduate degrees in various areas and many have two masters degrees, one in library science and another in such fields as economics, history, or the biologic and social sciences.

If you are a history buff, one of the more interesting areas of the Library is the Archive Section which houses documents and artifacts on the history of American medicine and the AMA.

The Library is always improving and enlarging its facilities. The last addition to the services was the International Health Section which has made it possible for all of the Library services to follow you, as a member of the AMA, wherever you go, whether it be the remote mountain stretches of West Pakistan, the rain forests of Brazil, or a center of civilization such as Paris.

If you are planning an overseas trip or sabbatical, to set up practice or to attend a meeting or congress, the Library can give you all the information you need on foreign medical organizations, hospital and medical facilities in various countries, living conditions, what you should bring and the locations of the nearest American physician in any country.

The staff can also furnish you with information on a comprehensive and up-to-date listing of medical meetings outside the United States. After you are situated abroad, the Library will continue to provide you with research facilities and photocopy services on specific medical subjects just as they did when you were stateside.

ANNOUNCEMENTS

Graduate Courses in Philadelphia

The Hahnemann Medical College and Hospital lists, for this fall and next spring, the following post-graduate courses:

General Internal Medicine — Wednesdays, October 4th, 1967 through March 27, 1968

Congestive Heart Failure — November 13 and 14, 1967

Sexual Function and Dysfunction — November 17 and 18, 1967

Psychodelic Drugs — March 18, 19, and 20, 1968

Management of Pre- and Post-operative Cardiopulmonary Patients — April 8, 9, and 10, 1968

Auscultation of The Heart — May 27 through 31, 1968

Psychiatry In Internal Medicine — November 18, 19, and 20, 1968

For more details, write to the Director of Postgraduate Education, Wilbur W. Oaks, M.D., Hahnemann Medical College, 230 North Broad Street, Philadelphia, Pennsylvania 19102.

Hypnosis Courses Available

Columbia University announces two courses in hypnosis for physicians, to be held on Saturdays, starting October 7, 1967.

The basic course will be given for seven consecutive Saturdays (October 7th through November 18th) from 10 a.m. until 5 p.m., with an hour luncheon break. There will be lectures, case demonstrations, practice sessions, movies, slides, and seminars. The course is open to the general physician and all specilaties. The fee is $175.

The second course — "Hypnosis and Psychiatry" — is open only to psychiatrists who have taken the basic hypnosis course or its equivalent. This runs for four Saturdays, January 6 through 27, 1968, and the fee is $100.

For application forms, write to Melvin D. Yahr, M.D., Assistant Dean, College of Physicians and Surgeons, 630 West 168th Street, New York, New York 10032.

Psychosomatic Seminar In Philadelphia

Two courses in psychosomatics will be available in Philadelphia this fall. An Advanced Seminar in Psychosomatic Medicine will be given on ten Wednesdays starting October 25, 1967. The program runs from 10 a.m. to 1 p.m. Tuition fee is $30.

A basic course in psychosomatics is offered on 20 Wednesdays starting on October 4, 1967. This program runs from 10 a.m. to 3 p.m. Tuition fee is $40.

Both courses are given at the Temple University Health Center, 3400 North Broad Street, Philadelphia. For more details, write to Dr. Barney Dlin, at 230 West Allens Lane, Philadelphia 19119.

Psychiatry For The Physician

Reserve Wednesday afternoon, November 8, for a seminar on psychiatry for the general practitioner, to be held at the Robert Treat Hotel in Newark. The program starts at 1:30 p.m. and terminates promptly at 5:00 p.m. This seminar is under the auspices of the Carrier Clinic Foundation. It is co-sponsored

by The Medical Society of New Jersey and by the New Jersey District Branch of the American Psychiatric Association.

The panel of distinguished speakers includes:

Robert H. Felix, M.D., Dean, University of St. Louis Medical School

Beverley Mead, M.D., Professor and Chairman of Department of Psychiatry, Creighton University

Herbert C. Modlin, M.D., Professor of Psychiatry, University of Kansas

John Nurnberger, M.D., Professor and Chairman of Department of Psychiatry, Indiana University Medical Center

Wives and guests of those who attend are invited to a reception at 5:00 p.m. in the Grand Ballroom.

National Conference On The Medical Aspects Of Sports

The Ninth National Conference on the Medical Aspects of Sports, sponsored by the American Medical Association will be held in Houston, Texas, at the Hotel American on November 26, 1967. The Conference is held annually in conjunction with and on the first day of the Clinical Convention of the American Medical Association. This meeting will cover a wide range of subjects of interest to those serving school and college athletic programs. Included will be sections relating to prevention of knee injuries, sports cardiology, and quackery in sports. Sessions will be devoted to common clinical conditions of variable significance in the athletic setting (e.g., gastroenteritis, concussions, genitourinary tract injuries, and rib injuries). Eduardo Hay, M.D., Director General of the Centro Deportivo Olimpico Mexicano, will discuss preparations for the 1968 Olympic Games. The Conference is open to key nonmedical athletic personnel as well as interested physicians. Further information concerning the Conference is available from the Committee on the Medical Aspects of Sports, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Scholarships For Medical Assistants

Loans for medical assistant training are now available from the Maxine Williams Scholarship Fund, sponsored by the American Association of Medical Assistants. Each loan is for $300. AAMA assumes all administrative costs and there is no interest rate. Repayment may be made after the student is employed.

Any high school graduate who wishes to take formal training is eligible to apply for a loan. Application blanks are available from the Association of Medical Assistants headquarters, 510 N. Dearborn St., Chicago, Ill. 60610. The fund, named in honor of the Association's first president, is supported entirely by private contributions. It was established to encourage those wishing to become medical assistants to take formal training, preferably at a school which offers a two-year course.

New Jersey Psychoanalytic Society

The New Jersey Psychoanalytic Society, an affiliate society of the American Psychoanalytic Association, reports that at its annual business meeting on April 13th the following officers were elected: President, Samuel A. Weiss, M.D., East Orange; President-elect, Benedict J. Bernstein, M.D., Maplewood; Secretary, Lawrence Deutsch, M.D., Englewood; Treasurer, Ira L. Mintz, M.D., Englewood. The councilor to the national organization is Howard Schlossman, M.D., Englewood, and his alternate is Raymond Gehl, M.D., Maplewood.

Sexual Abuse Of Children

The American Humane Association has made available a brochure, "Sexual Abuse of Children," for interested physicians and social workers. These pamphlets are available for 35¢ each from the American Humane Association, P.O. Box 1266, Denver, Colorado.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1967

September

12 Bergen County Medical Society

14 Burlington County Medical Society
Scientific/Business

19 Passaic County Medical Society

21 Somerset County Medical Society

26 Cape May County Medical Society

27 Monmouth County Medical Society

27 The Academy of Medicine of New Jersey
Workshop on Cardiac Auscultation

October

3 Hudson County Medical Society

10 Bergen County Medical Society

10 Cumberland County Medical Society

11 Ocean County Medical Society

12 Burlington County Medical Society
Scientific/Business

17 Warren County Medical Society

18 Middlesex County Medical Society

18 Passaic County Medical Society

19 Morris County Medical Society

24 The Academy of Medicine of New Jersey and Rutgers Medical School
Rutgers, The State University, New Brunswick
Immunology Workshop

November

7 Hudson County Medical Society

8 Ocean County Medical Society

8 The Academy of Medicine of New Jersey and Rutgers, The State University
The Rutgers Law School, Newark
"A Colloquium on Abortion"

9 Burlington County Medical Society
Scientific/Business

14 Bergen County Medical Society

15 New Jersey State Dental Society
Semi-Annual Session

15 Middlesex County Medical Society

15 The Academy of Medicine of New Jersey
Newark City Hospital
Workshop on Cytogenetics

17 Morris County Medical Society

21 Passaic County Medical Society

22 Monmouth County Medical Society

28 Cape May County Medical Society

December

5 Hudson County Medical Society

6 The Academy of Medicine of New Jersey
"Antibiotic Induced Toxic and Hypersentivity Reactions"

12 Bergen County Medical Society

12 Cumberland County Medical Society

13 Ocean County Medical Society

14 Burlington County Medical Society
Scientific/Business

20 Middlesex County Medical Society

1968

March

13 The Academy of Medicine of New Jersey
Mountainside Hospital, Montclair
Symposium on Supraventricular Arrhythmias

OBITUARIES

Dr. Rafael D. Gilady

On July 1, 1967, Dr. Rafael D. Gilady retired as chief medical examiner of Bergen County. And on July 7, he died at his home. Dr. Gilady was born in Israel (or, as it then was, Palestine) in 1892 and and came to the U.S.A. at the age of 18. In 1916 he received his M.D. at Bellevue and then interned at the Hackensack Hospital. He concentrated on clinical pathology and internal medicine, and was identified with both Bergen Pines and the Hackensack Hospitals.

Dr. William C. Gordon

At the untimely age of 56, Dr. William C. Gordon, one of Passaic County's most prominent practitioners, died on May 29, 1967. Born in New York City, he received his M.D. at the University of Maryland in 1937. From 1941 to 1946 he served in the Medical Corps of the Army, going through the ranks from lieutenant to major. He was in general practice in Wanaque and was affiliated with Paterson General, St. Joseph's and Chilton Memorial Hospitals. He was active in the affairs of the Passaic County Medical Society, the American Legion, and the Veterans of Foreign Wars. Dr. Gordon was Assistant Medical Examiner of Passaic County.

Dr. John F. Johnson

One of the Delaware Valley's most useful medical citizens died on July 12, 1967 at the age of 58, with the passing that day of Dr. John F. Johnson. Only two years ago he served as president of our Mercer County Society. He was a F.A.C.S. and a board diplomate in surgery. He initiated the medical secretarial courses at Rider College. He was medical director of General Motors in the Trenton area. He was chief of surgery at St. Francis Hospital. His M.D. came (in 1933) from the University of Michigan, but he taught anatomy at the Jefferson Medical College. Born in Boston, he did his internship at the Presbyterian Hospital in Chicago, 1933-34, and then went to Detroit as a surgical resident at the Henry Ford Hospital, 1934-36. Dr. Johnson then settled in Trenton and had been serving the people of that area for the past 30 years.

Dr. Joseph J. Kralik

Born at the turn of the century, Dr. Joseph J. Kralik, a well-known Newark general practitioner and industrial physician, died on June 21, 1967.

Dr. Kralik received his M.D. at Baylor in 1928 and interned in St. Elizabeth Hospital in Elizabeth, New Jersey. He maintained staff affiliations with all three general hospitals in Elizabeth, but was most active at St. James Hospital in Newark. He was engaged in the affairs of the Essex County Medical Society, and was a leader in the New Jersey Workmen's Compensation Medical Society.

Dr. Robert S. McTague

Robert S. McTague, born in Jersey City in 1909, died at the Monmouth Medical Center on July 10, 1967. He was 58 at the time of his death. Dr. McTague was a civic leader and, indeed, was Mayor of Atlantic Highlands for several years. His M.D. came from Georgetown in 1933. He was the Highlands School Physician for many years and was on the staff of the Monmouth Medical Center. Dr. McTague was happy to be known as a general practitioner, though his major interest was in obstetrics and he served the Monmouth Medical Center in that capacity. He was secretary of his county association of Holy Name Societies and was active in civic, welfare, and church affairs in the Monmouth County area.

Dr. Charles A. Munro

Dr. Charles A. Munro, a prominent south Jersey practitioner, died on May 28, 1967 at the Burlington Memorial Hospital. Born in 1901, Dr. Munro received his M.D. degree at McGill in 1931. The following year, he

opened his office for general practice in Marlton and served the people of Burlington and Camden Counties in the three decades since then. He was physician to the county jail in Mt. Holly and the school doctor for St. Joseph's school in Medford, New Jersey. He was active in the affairs of our Burlington County Component Society, serving in many capacities. He was president of the Burlington County Medical Society in 1939 and 1940. He was active in civic and masonic affairs in his community and was on the staff of the Burlington County Memorial Hospital.

Dr. Raphael Remondelli

Like most of us, Ralph Remondelli wanted to die with his boots on. While preparing to do surgery at Clara Maas Hospital, he suddenly collapsed and suffered a fatal coronary attack on June 23, 1967. Ralph Remondelli was one of the most vigorous organizational leaders of medicine in northern New Jersey. For more than a decade, he had been secretary of the Essex County Medical Society. He was medical director of the hospital where he died. He was a F.A.C.S., a trustee of the Welfare Federation, and an attending surgeon at Columbus Hospital. Dr. Remondelli was born in Newark in 1909, held an M.S. degree (University of Pennsylvania), and earned his M.D. at Columbia University's P & S in 1933. He was involved in many civic and medical activities throughout the state.

Dr. Jacob Roemer

Jacob Roemer, M.D., a pioneer radiologist of Paterson, died June 22, 1967 in Los Angeles at the age of 84. He had served the Paterson community from his first days as a general practitioner in 1909 until his retirement from active practice as a radiologist fifty years later. In 1932, Dr. Roemer was President of the Passaic County Medical Society. He had played a key role in the local operations of the Federal Emergency Relief Administration, which brought medical care to the massive numbers of the unemployed and poor. He was one of the organizers of the Barnert Memorial Hospital in 1913. He was its first pathologist and anesthetist.

He began his studies in the then new field of roentgenology as early as 1915. When the American Board of Radiology was established in 1934, Jacob Roemer became one of its charter Diplomates. At the Barnert Memorial Hospital, Dr. Roemer inaugurated the X-ray department, serving as its director for some twenty years. He was also Chief of the Medical Staff of the hospital for six years, 1920 to 1926, and did not retire from the active staff until 1955 at the age of 73.

The first radiation therapy for cancer in Paterson was given in the office of Dr. Roemer. For several years before local hospitals had developed radiologic services, hospital patients were brought by ambulance to his office for this treatment.

BOOK REVIEWS

Modern Treatment: Treatment of Shock. Leslie A. Kuhn, M.D., Editor; **Treatment of Arterial Disorders of the Extremities,** David I. Abramson. M.D., Editor. New York, 1967, Hoeber Medical Division, Harper & Row. Pp. 214 ($16. per year, by subscription)

The physiologic theory, some of the experimental background and the treatment of shock are here reviewed, somewhat unevenly, by five authorities. A large complex literature had to be digested and only the most reliable studies selected for summary. The essay of Dr. Kuhn (cardiogenic shock) and that of Dr. Lillehei, *et al.* (septic shock) are particularly good.

Recommendations for clinical management are practical, clear cut, simple and well documented. The authors succinctly describe the "how to" and use of clinical testing. The writers carefully provide a step-by-step use of drugs and monitoring equipment. Sufficient detail is provided to encourage the reader to use this book directly at the beside. The three remaining essays are competent but faulted by unnecessary overlapping, repetition and inadequate digestion of published experience and thinking in their area of discussion. There is excessive reference to the writers' own prior publications.

For the expenditive of but two or three hours this book provides a good review of a vital topic recently hit by an information explosion. The text needs a stronger hand in editing, but it is recommended reading in the opinion of this reviewer. NORMAN RIEGEL, M.D.

Neuro-Ophthalmology. J. Lawton Smith, M.D., Editor. St. Louis, 1967, Mosby. Pp. 349. Illustrated. ($25.)

This volume records the presentations of a symposium sponsored by the Department of Ophthalmology, University of Miami School of Medicine. The material is divided into sixteen chapters, each of which is a separate entity, not necessarily related to the others. This compilation is not merely of interest to ophthalmologists, but also to neurologists, neurosurgeons, and pediatricians. There is emphasis on material relating to pediatric neuro-ophthalmology and ophthalmic neuropathology.

To those who are clinically oriented, this text may seem to put too much emphasis on the experimental and pathologic findings. Since J. Lawton Smith is the editor, it is not surprising to find three of the chapters dealing with syphilis and its relation to the eye.

On the whole, most of the writing is concise, which makes the book easy to read. An exhaustive bibliography is appended to each section.

The book is recommended only for those having a more than casual interest in neuro-ophthalmology.

BERNARD SUSSKIND, M.D.

Hearts: Their Long Follow-Up. Paul Dudley White, M.D. and Helen Donovan. Philadelphia, 1967, Saunders. Illustrated. Pp. 357. ($12.00)

This delightful book is instructive and long overdue in view of the tremendous experience of the author. Dr. White's honesty, warmth, and accurate scientific observations are worth every moment spent with this excellent presentation. Each of the eighty-six reports is truly a gem in the finest tradition of the clinician. Though it is true that many of these are rather unusual and possibly not-often-to-be-seen-again cases, they are certainly worth reading for every physician and particularly for the intern and resident to teach the need for humility as well as patience. The subtle pearls found throughout are jewels that will rarely be found again any place because so few men will ever have a chance to follow cases so closely and in such a unique fashion in their lifetime.

From the clinician's point of view the value of each case report is unique because of the wisdom, experience, and depth of the man who is reporting these cases. These facts, coupled with the unique findings in many of these patients, make the reading of this clinical presentation sound almost like a mystery novel rather then the usual cold clinical dissections that we normally find in our journals.

The book is divided into twenty chapters, each of which is devoted to a separate disease entity e.g., "The Follow-up of the Normal Heart," Cardiovascular Syphilis," "Trauma," and "Centenarians" as well as "Diverse and Sundry." Of great interest is *L'Envoi* in which the author thanks his patients for what they have taught him through the years — a truly stimulating tribute by a man of outstanding virtue.

All in all, this is a volume that every physician interested in cardiology should have in his library. It will remind him of the fact that, though statistics are important and that we must know the story of the usual, it is truly the unusual patient that makes our lives interesting and worthwhile.

ARTHUR BERNSTEIN, M.D.

Diabetes For Diabetics: A Practical Guide. George F. Schmitt, M.D. Miami, Florida, 1965, Diabetic Press of America, Inc. Illustrated. Pp. 237. (price not stated)

This is the third printing of one of the many manuals for diabetics. Each has its individual author's attitude and occasional prejudices, and each claims to be "the word." By the author's admission the volume proposes "a fresh approach;" yet it also purports to represent the distillation of what preceptors and patients have taught the author. Other purposes are to raise funds to send "diabetic children to camp, for the education of diabetic patients, and for research in diabetes." This is a large order but, with few exceptions, rather well handled.

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Neuro-Ophthalmology. J. Lawton Smith, M.D., Editor. St. Louis, 1967, Mosby. Pp. 349. Illustrated. ($25.)

This volume records the presentations of a symposium sponsored by the Department of Ophthalmology, University of Miami School of Medicine. The material is divided into sixteen chapters, each of which is a separate entity, not necessarily related to the others. This compilation is not merely of interest to ophthalmologists, but also to neurologists, neurosurgeons, and pediatricians. There is emphasis on material relating to pediatric neuro-ophthalmology and ophthalmic neuropathology.

To those who are clinically oriented, this text may seem to put too much emphasis on the experimental and pathologic findings. Since J. Lawton Smith is the editor, it is not surprising to find three of the chapters dealing with syphilis and its relation to the eye.

On the whole, most of the writing is concise, which makes the book easy to read. An exhaustive bibliography is appended to each section.

The book is recommended only for those having a more than casual interest in neuro-ophthalmology.

BERNARD SUSSKIND, M.D.

Hearts: Their Long Follow-Up. Paul Dudley White, M.D. and Helen Donovan. Philadelphia, 1967, Saunders. Illustrated. Pp. 357. ($12.00)

This delightful book is instructive and long overdue in view of the tremendous experience of the author. Dr. White's honesty, warmth, and accurate scientific observations are worth every moment spent with this excellent presentation. Each of the eighty-six reports is truly a gem in the finest tradition of the clinician. Though it is true that many of these are rather unusual and possibly not-often-to-be-seen-again cases, they are certainly worth reading for every physician and particularly for the intern and resident to teach the need for humility as well as patience. The subtle pearls found throughout are jewels that will rarely be found again any place because so few men will ever have a chance to follow cases so closely and in such a unique fashion in their lifetime.

From the clinician's point of view the value of each case report is unique because of the wisdom, experience, and depth of the man who is reporting these cases. These facts, coupled with the unique findings in many of these patients, make the reading of this clinical presentation sound almost like a mystery novel rather then the usual cold clinical dissections that we normally find in our journals.

The book is divided into twenty chapters, each of which is devoted to a separate disease entity e.g., "The Follow-up of the Normal Heart," Cardiovascular Syphilis," "Trauma," and "Centenarians" as well as "Diverse and Sundry." Of great interest is *L'Envoi* in which the author thanks his patients for what they have taught him through the years — a truly stimulating tribute by a man of outstanding virtue.

All in all, this is a volume that every physician interested in cardiology should have in his library. It will remind him of the fact that, though statistics are important and that we must know the story of the usual, it is truly the unusual patient that makes our lives interesting and worthwhile.

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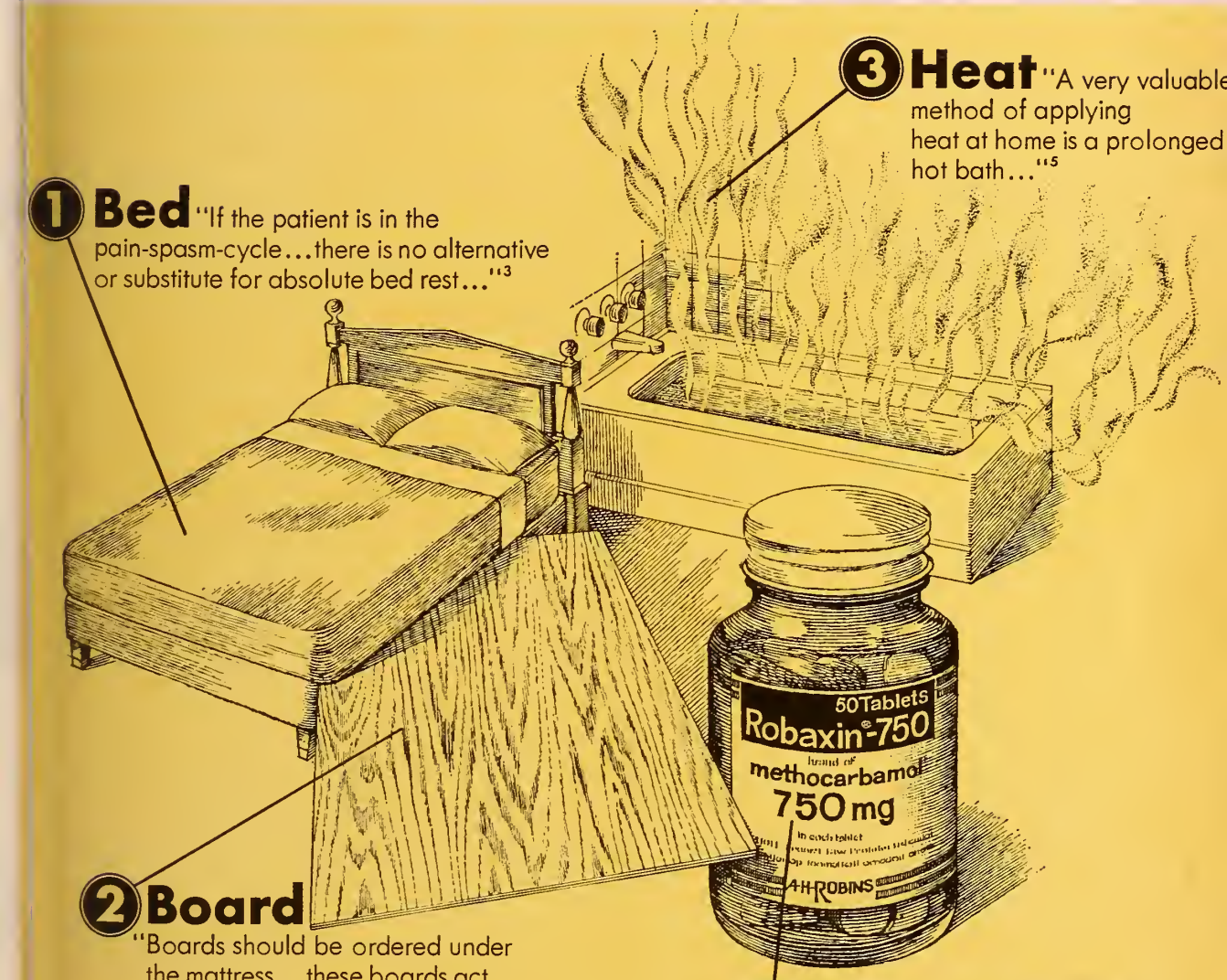
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LOW-BACK PAIN

A CONSERVATIVE, FOUR-POINT PROGRAM

The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.[1,2] For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:



1 Bed "If the patient is in the pain-spasm-cycle...there is no alternative or substitute for absolute bed rest..."[3]

2 Board "Boards should be ordered under the mattress...these boards act by immobilizing the spine..."[4]

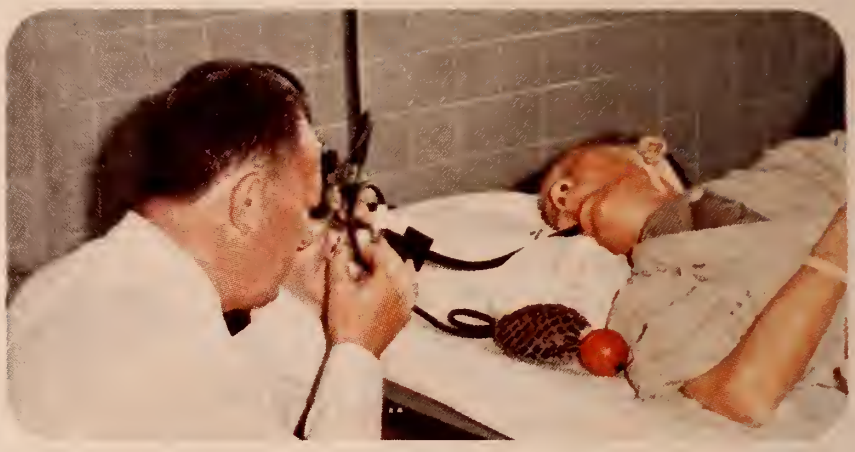
3 Heat "A very valuable method of applying heat at home is a prolonged hot bath..."[5]

4 Robaxin®-750 (methocarbamol, 750 mg. capsule-shaped tablets) A well-tolerated[6] skeletal muscle relaxant, methocarbamol helps relieve spasm "...without interfering with normal tone and movement."[7] And there is little likelihood of sedation.[6]

ndicated far relief of skeletal muscle spasm. **Contraindicated in** ypersensitive patients. **Side Effects** (lightheadedness, dizziness, rowsiness, nausea) may occur rarely, but usually disappear on reduced osage. Hypersensitivity reactions develop infrequently. See product erature far further details. **Also available:** Robaxin® Tablets nethocarbamol, 500 mg.) Robaxin Injectable (methacarbamol, 1 Gm./10 cc.)

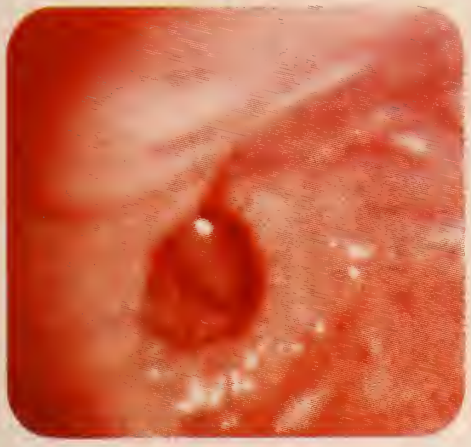
eferences: (1). Gadfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gattschalk, A.: GP 33:91, 1966. (3). Rawe, M.L.: J. Occup. Med. 2:219, 1960. 4). Cozen, L.: South Dakota J. Med. 18:26, 1965. (5). Sato-Hall, R.: ed. Sc. 14:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteapath. A. :142, 1962. (7). Feuer, S.G., et al.: New York J. Med. 62:1985, 1962.

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NEW EVIDENCE:

Pro-Banthīne® (propantheline bromide)
gives positive, selective benefits in gastrointestinal disorders.



Intragastric photograph of pyloric region showing complete relaxation of pyloric sphincter with 6 mg. of Pro-Banthine intravenously.

AN IMPORTANT PROBLEM in managing gastrointestinal disorders has been the choice of an anticholinergic agent which will act positively and selectively on the gastrointestinal tract without extensive secondary effects.

Recent direct observations with the cinefibergastroscope and intragastric photography[1] visually confirm previous evidence that Pro-Banthine does, indeed, possess such selective activity.

Barowsky and his associates demonstrated that a minimal dose of 6 to 8 mg. of Pro-Banthine intravenously produced complete relaxation of gastric activity. Secondary effects were not significant.

By contrast, it required 0.8 mg. or double the usual dose of atropine intravenously to achieve similar gastric relaxation. Side effects of this dosage of the belladonna alkaloid were pronounced. Ventricular rates were as high as 150 per minute.

For positive, selective anticholinergic benefits Pro-Banthine is indicated in patients with peptic ulcer, gastritis, irritable colon and other forms of gastrointestinal hypermotility.

Dosage: The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type ampuls of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

Contraindications: In glaucoma or severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in the elderly male with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug.

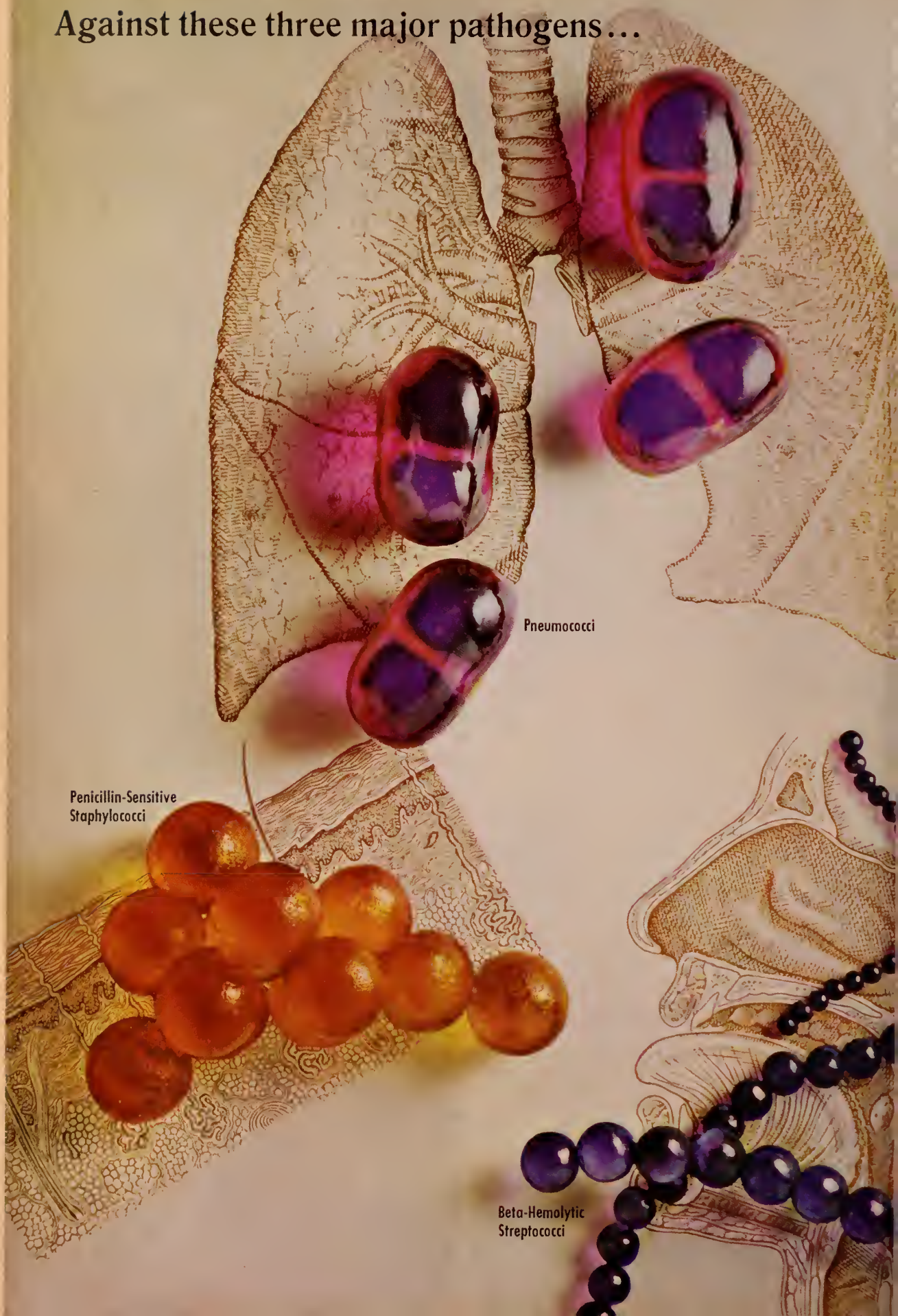
Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

Side Effects The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

1. Barowsky, H.; Greene, L.; Bennett, R., and Buganza, G.: The Effect of Anticholinergic Drugs on Gastric Motility and Pyloric Function, Scientific Exhibit, Annual Convention of the American Medical Association, Chicago, Illinois, June 26-30, 1966.

SEARLE *Research in the Service of Medicine*

Against these three major pathogens...



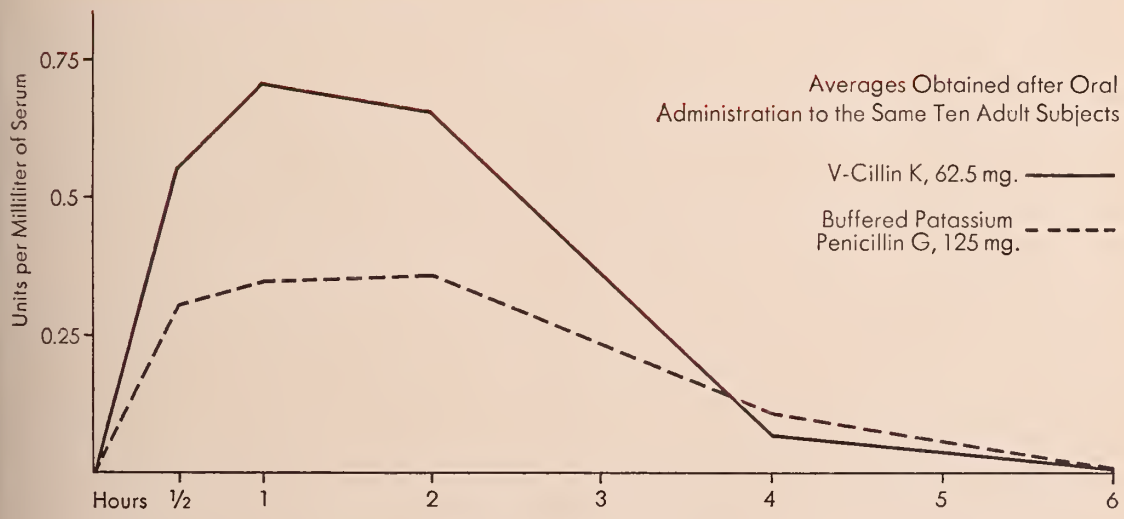
V-Cillin K® provides dependable oral antibacterial activity

because it combines a high degree of in-vitro activity...

Antibiotic	Staph. Aureus (Penicillin-Sensitive) MIC (mcg./ml.) Median	Range	Streptacaccus, Graup A MIC (mcg./ml.) Median	Range	Diplacoccus Pneumaniae MIC (mcg./ml.) Median	Range
Penicillin V	0.02	0.02-0.04	0.02	0.003-0.4	0.01	0.005-0.2
Penicillin G	0.02	0.005-1.6	0.005	0.002-0.2	0.02	0.01-0.1
Methicillin	1.6	0.4-6.3	0.2	0.1-0.4	0.2	0.1-1.6
Oxacillin	0.4	0.1-3.1	0.04	0.02-0.4	0.1	0.04-0.8
Cloxacillin	0.2	0.2-0.8	0.1	0.1-0.8	—	—
Nafcillin	0.4	0.2-0.8	0.04	0.02-0.1	0.02	0.02-0.2
Ampicillin	0.2	0.1-0.8	0.02	0.01-0.04	0.02	0.01-0.04

Adapted from Klein, J. O., and Finland, M.: New England J. Med. 269:1019, 1963.

with high blood levels, even in the presence of food



Adapted from Griffith, R. S., and Black, H. R.: Current Ther. Res., 6:253, 1964.

V-Cillin K® Lilly 700867

Potassium Phenoxymethyl Penicillin

(See next page for prescribing informat

New 500 mg. tablets...a more convenient way to give high dos



Description: V-Cillin K is the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly). This chemically improved form combines acid stability with immediate solubility and rapid absorption. Higher serum levels are obtained more rapidly with this penicillin than with equal oral doses of penicillin G. The higher serum levels and acid stability of V-Cillin K make it a more dependable penicillin for oral use.

V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

Indications: V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Warnings: In rare instances, the use of penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin and in those with bronchial asthma or other allergies. Resuscitative drugs should be readily available for emergency administration. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for relief of immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly parenteral dosage schedules, frequent evaluation of the r hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laborato (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overg pencillin-insensitive organisms. In such cases, its administrati be discontinued, and appropriate measures should be taken

Adverse Reactions: Although serious allergic reactions are common with administration of oral penicillin than with intra forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it does possess cant index of sensitization. The following hypersensitivity associated with the use of penicillin have been reported: sk ranging from maculopapular eruptions to exfoliative derma caria; and reactions resembling serum sickness, including ch edema, arthralgia, and prostration. Severe and often fatal an has occurred (see Warnings). Hemolytic anemia, leukopen bocytopenia, and nephropathy are rarely observed side-ef are usually associated with high parenteral dosage.

Administration and Dosage: For Tablets V-Cillin K and for Pediatric, the usual dosage ranges from 125 mg. (200,000 un times a day to 500 mg. (800,000 units) every four hours. Fo the daily dosage may be 50 mg. per Kg. of body weight div three doses.

Beta-hemolytic streptococcus infections without associa teremia may be treated with 200,000 to 400,0000 units thre day. Therapy should be continued for a minimum of ten days t development of rheumatic fever and/or other serious comp Dosage for routine streptococcus prophylaxis in patients with of rheumatic fever or congenital heart disease may be 200, once or twice daily. When such patients undergo tonsillecto extraction, or other minor surgery, the prophylactic dose s 500,000 units every six hours given two days prior to surger two days postoperatively. If oral medication is not feasible o of surgery, parenteral therapy should be considered. Mild t ately severe pneumococcus pneumonia has been treated e with 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should every six to eight hours in conjunction with indicated surgic dures.

For gonorrhea in males, 500 mg. (800,000 units) every four three doses may be employed; in females, 500 mg. every fo for six doses are recommended. Refractory infections generally to a second treatment three to four days following completi first. Treatment of gonorrhea with severe complications sh individualized, with prolonged and intensive treatment. Patier suspected lesion of syphilis should have a dark-field examin fore receiving penicillin and monthly serologic tests for a mi three months.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 bottles of 50 and 100; and 250 mg. (400,0000 units) and (800,000 units), in bottles of 24 and 100.

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 u 5 cc. of solution, in 40, 80, and 150-cc.-size packages.

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Tuinal helps wakeful patients fall asleep fast, stay asleep all night.

Indications: Tuinal is indicated for prompt and moderately long-acting hypnosis. It is not suitable for continuous daytime sedation.

Contraindications: Barbiturates should not be administered to anyone with a history of porphyria, nor should they be given in the presence of uncontrolled pain, because excitement may result.

Warning: May be habit-forming.

Precautions: Tuinal should be used cautiously in patients with decreased liver function, since prolongation of effect may occur.

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Dosage: 50-200 mg. (¾-3 grains) at bedtime.

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Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) of liquid contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. **Dosage:** one or two tablets, well chewed or allowed to dissolve in the mouth, or one or two teaspoonfuls of liquid to be taken between meals and at bedtime.

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Should you? In the face of the fact that the Council on Drugs of the American Medical Association has for some time advised against it?[1] And now the new (1967) United States Dispensatory says much the same thing, in even stronger terms—that the drug in question is neither a broad-spectrum antibiotic in the sense that the tetracyclines are, nor is it even the first penicillin with a wider range of antibacterial action.[2]

Should you, for example, in treating pneumonia? The rationale for using this penicillin in pneumonia is that it is effective against *Hemophilus influenzae* as well as against *Diplococcus pneumoniae*.

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But what about *Mycoplasma pneumoniae*, which may be better known to you as Eaton Agent? No penicillin is known to be effective against this common cause of pneumonia. DECLOMYCIN is.

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When you consider using a drug *like* a broad-spectrum antibiotic, why not use a *true* broad-spectrum antibiotic? Like DECLOMYCIN.

References: 1. A.M.A. Council on Drugs: *New Drugs* 1966 ed. Chicago: American Medical Association, p. 12. 2. Osol, A.; Pratt, R., and Altschule, M.D.: *The United States Dispensatory*, 26th ed. Philadelphia: J. B. Lippincott Co., 1967, p. 844. 3. Purcell, R. H., and Chanock, R. M.: Role of Mycoplasmas in Human Respiratory Disease. *Med. Clin. N. Amer.* 51:791 (May) 1967.

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Prescribing information on next page.

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DECLOMYCIN Demethylchlortetracycline should l equally or more effective than other tetracyclines wh the offending organisms are tetracycline-sensitive.

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Warning—In renal impairment, usual doses may lead excessive accumulation and liver toxicity. Under su conditions, lower than usual doses are indicated, and, therapy is prolonged, serum level determinations may b advisable. A photodynamic reaction to natural or arti cial sunlight has been observed. Small amounts of dr and short exposure may produce an exaggerated su burn reaction which may range from erythema to seve skin manifestations. In a smaller proportion, phot allergic reactions have been reported. Patients shou avoid direct exposure to sunlight and discontinue drug the first evidence of skin discomfort. Necessary subs quent courses of treatment with tetracyclines should b carefully observed.

Precautions—Overgrowth of nonsusceptible organism may occur. Constant observation is essential. If new i fections appear, appropriate measures should be take In infants, increased intracranial pressure with bulgir fontanels has been observed. All signs and symptom have disappeared rapidly upon cessation of treatmen

Side Effects—Gastrointestinal system—anorexia, nause vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pr ritus ani. Skin—maculopapular and erythematous rashe A rare case of exfoliative dermatitis has been reporte Photosensitivity; onycholysis and discoloration of th nails (rare). Kidney—rise in BUN, apparently dose r lated. Hypersensitivity reactions—urticaria, angioneuroti edema, anaphylaxis. Teeth — dental staining (yellov brown) in children of mothers given this drug during th latter half of pregnancy, and in children given the dru during the neonatal period, infancy and early childhoo Enamel hypoplasia has been seen in a few children. adverse reaction or idiosyncrasy occurs discontinue me ication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 m b.i.d. Should be given 1 hour before or 2 hours afte meals, since absorption is impaired by the concomitar administration of high calcium content drugs, foods an some dairy products. Treatment of streptococcal infe tions should continue for 10 days, even though symp toms have subsided.

Capsules: 150 mg; **Tablets:** film coated, 300 mg, 15 mg, and 75 mg of demethylchlortetracycline HCl.

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Typically, the obese patient is a repeat dieter. And with each failure, the task looks more hopeless. Therefore, it is often just as important to lift the mood as to curb the appetite. Desoxyn Gradumet does just that. It gently elevates and sustains the mood. And no other product—amphetamine or non-amphetamine—is more effective in suppressing appetite.

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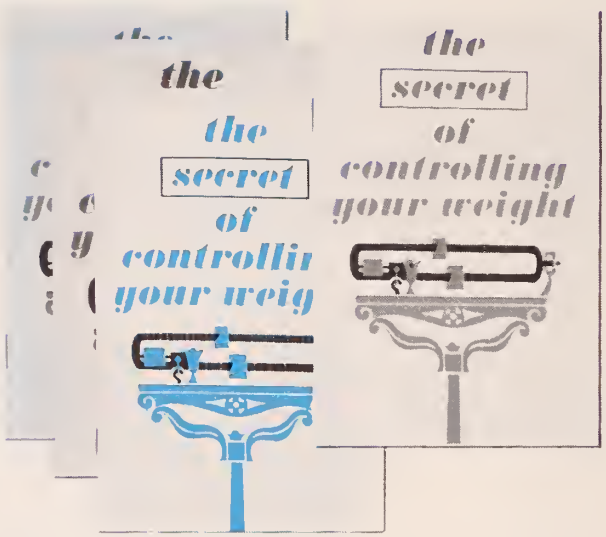
ECONOMY

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
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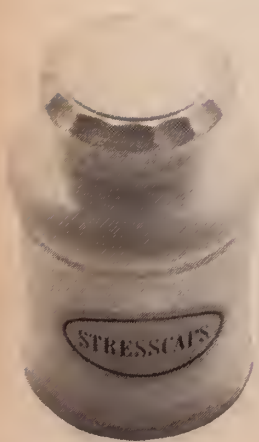
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References: 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rowls, W., et al.: Med. Times, 87:818, 1959.
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Meeting Place: Auditorium, Middlesex General Hospital,
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Time: Wednesdays, 9 to 11 A.M. starting September 20, 1967

Beginning this September and ending with the last Wednesday in May 1968, the Twelfth Postgraduate Course "Recent Advances in Internal Medicine and Therapeutics" will be given at Middlesex General Hospital in New Brunswick. As in the past, the Course is designed to provide clear and concise reviews of important advances during recent years in phases of internal medicine which are of immediate concern to New Jersey physicians in active practice. The Course provides university credit toward meeting the requirements of the AAGP (totaling 68 points for the 34 sessions) and includes material suitable for hospital educational programs and relevant discussions of basic sciences related to clinical medicine.

The Course consists of 34 two-hour sessions given weekly on Wednesday mornings, 9 to 11, in the Hospital Auditorium. The lecturers are outstanding members of metropolitan medical faculties, chiefly of New York City and Philadelphia. During the sessions opportunity is given to discuss with the speakers aspects of clinical problems which arise in the care of individual patients. The notes of the lectures are transcribed and distributed to physicians who attend the Course.

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The opening session is scheduled for Wednesday, September 20, 1967. IF YOU ARE INTERESTED IN ENROLLING AND HAVE NOT RECEIVED AN APPLICATION FORM, IT IS IMPORTANT THAT YOU WRITE IMMEDIATELY TO THE CHAIRMAN OF THE COURSE, DR. S.E. MOOLTEN, MIDDLESEX GENERAL HOSPITAL, NEW BRUNSWICK, N.J. The fee for the entire Course (34 sessions) is $125 (for Fellows of either Academy the fee is $110; for interns and residents $35).

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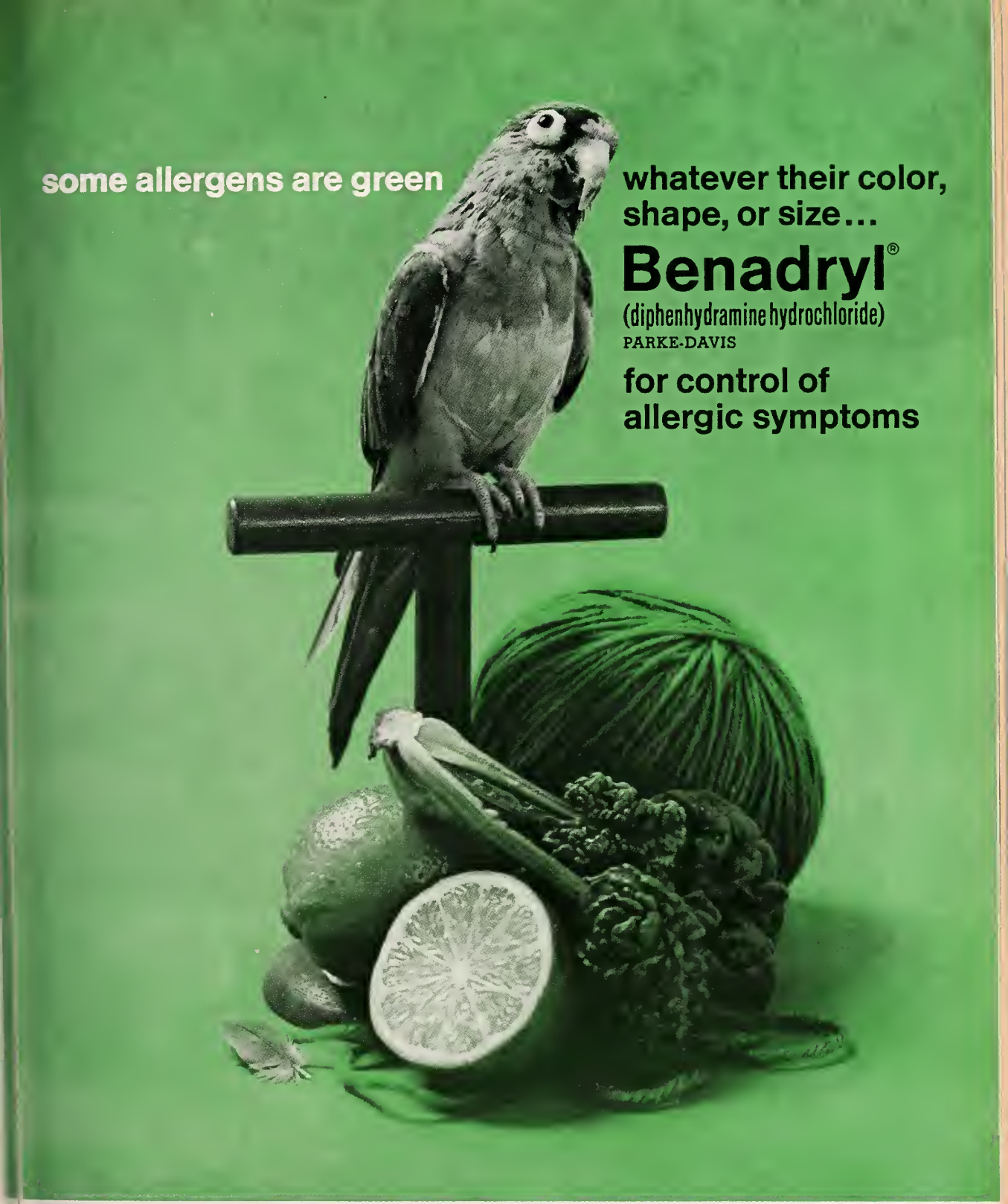
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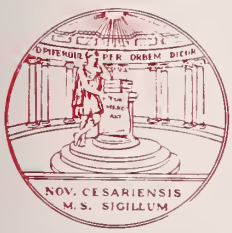
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the JOURNAL
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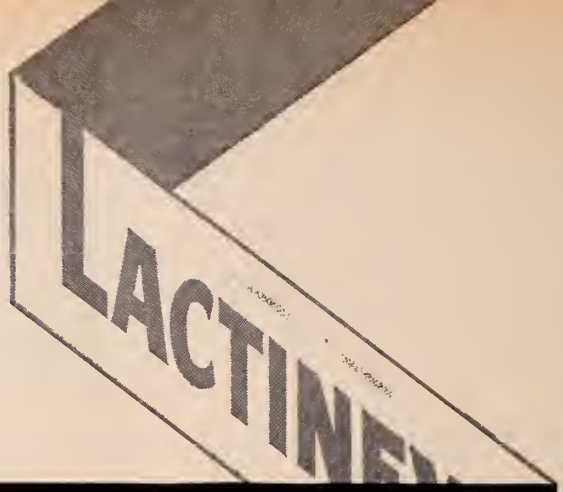
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(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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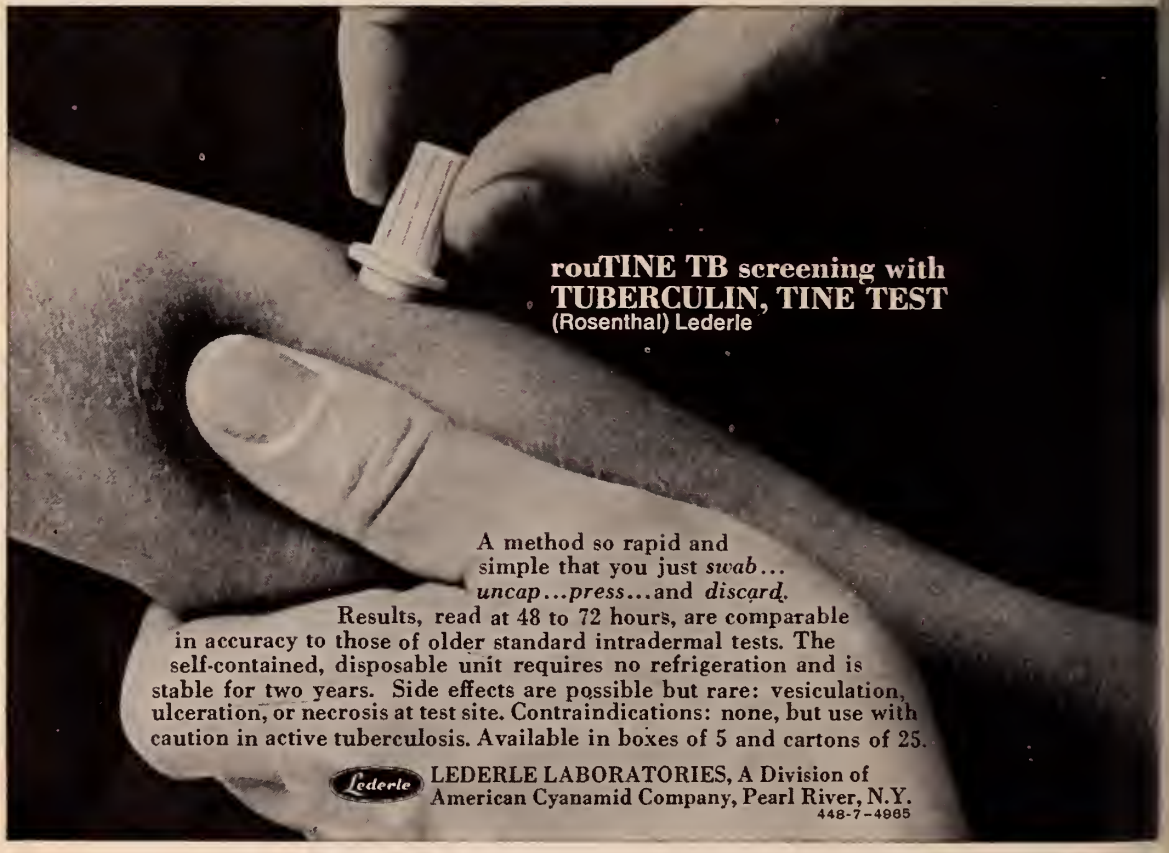
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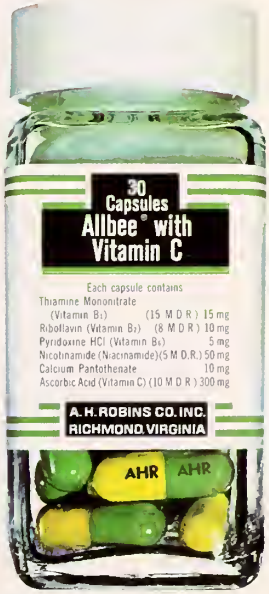
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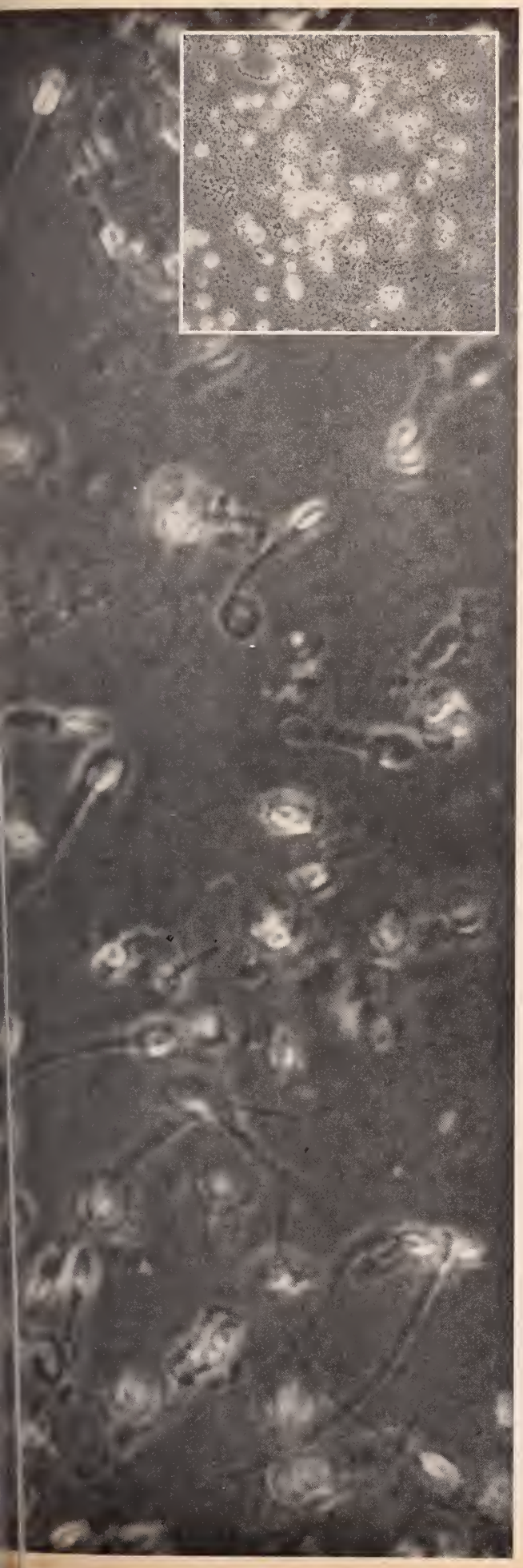
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New view of an oral contraceptive at work

Although suppression of ovulation remains the primary mode of action of oral contraceptives, newer knowledge indicates that products like Norinyl-1—a combination of both low-dosage progestogen and estrogen for the full treatment cycle—may provide multiple action that helps explain their unexcelled record of contraceptive effectiveness. This report explores the possible secondary protective mechanisms offered by combined hormonal administration.

Accumulating evidence has indicated that sparse, highly viscous cervical mucus has a possible adverse effect on the motility and survival of spermatozoa.

The estrogen-opposing progestational ingredient of Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.) changes the usual mid-cycle picture of a thin, watery cervical mucus. The result—a built-in barrier that appears to inhibit sperm from reaching the ovum should one be released. The inset in the adjoining photograph shows immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

See last page for contraindications, precautions, side effects and dosage.

How the estrogen-opposing action of Norinyl-1 creates cervical mucus that may be hostile to sperm penetration

Normally, estrogen activity during the fertile midcycle stimulates the production of a profuse and watery cervical mucus that permits maximum sperm motility and promotes penetration.

But what happens when Norinyl-1 is administered? Its potent progestogen, norethindrone, opposes estrogen stimulation of cervical mucus. Consequently, the amount of mucus decreases and its viscosity increases. This results in a sparse but thick mucus barrier that appears to diminish the vitality of the sperm and to impair its powers of penetration.

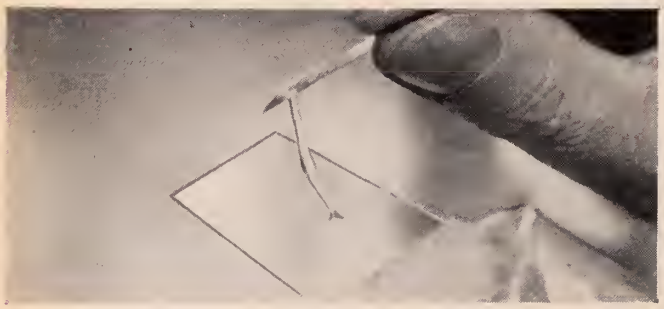
The role of viscous cervical mucus as a secondary action of Norinyl-1

In a report on 89 patients taking this medication,* cervical mucus obtained from cycle day 5 to cycle day 29 appeared scant and thick and exhibited little or no Spinnbarkeit.

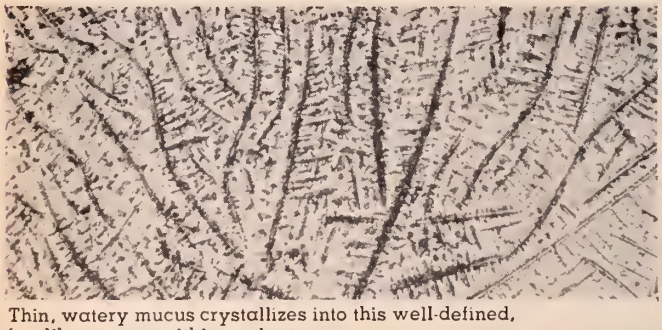
In the opinion of this investigator, the effect on cervical mucus may be sufficient to prevent conception.

*Cohen, M. R.: Symposium: Mechanisms of Action of Low Dosage Oral Contraceptive, Yale University Medical Center, New Haven, Conn., Apri

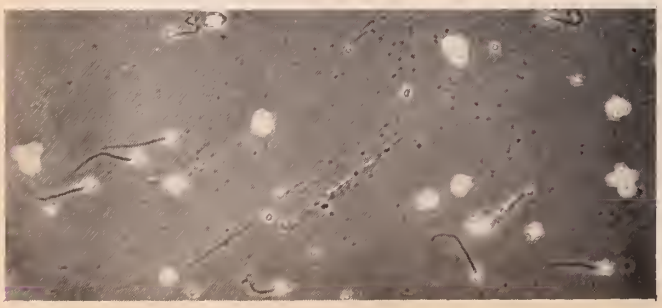
Normal cervical mucus at midcycle in untreated patient is known to permit sperm motility... promote sperm penetration.



Cervical mucus is thin and watery with a stretchability (Spinnbarkeit) of 15 to 20 cm.



Thin, watery mucus crystallizes into this well-defined, fernlike pattern within a minute.

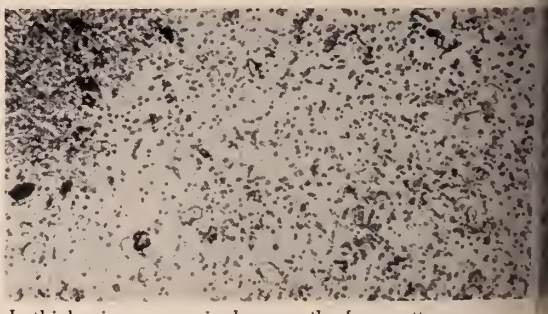


Spermatozoa appear healthy, are active and freemoving.

Viscous cervical mucus at midcycle produced by Norinyl-1 appears to impair sperm vitality... inhibit penetration.



Cervical mucus is scanty, thick and viscous. Spinnbarkeit is 1 cm. or less.



In thick, viscous cervical mucus the fern pattern is poorly defined or absent.

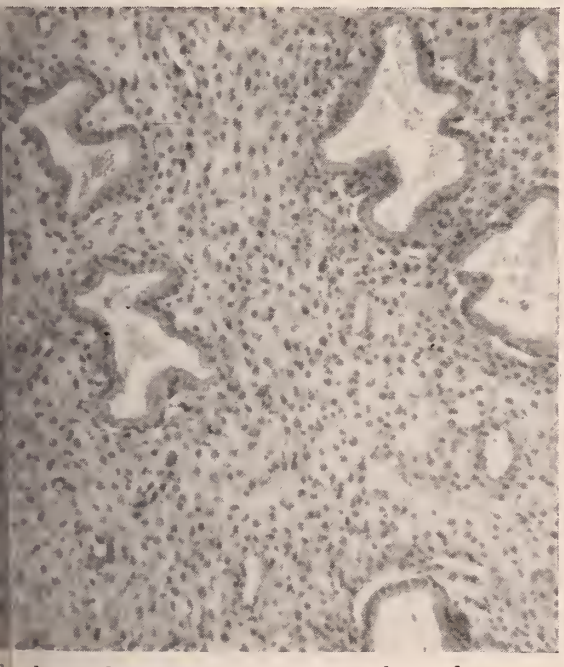


Immobile spermatozoa as they appear in cervical mucu taken from a patient treated with Norinyl-1.

w Norinyl-1
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tective mechanism

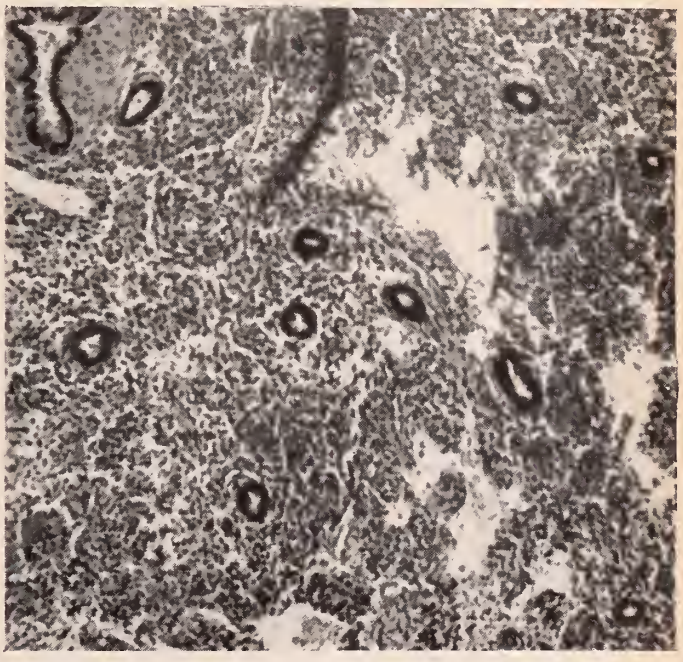
ppose that an ovum is released—as occurs in an
al, rare case—and somehow a sperm succeeds in
ing the cervical mucus barrier. Should this come about,
tional action of Norinyl-1 may protect the patient
vanted pregnancy. The theory is that progestogen intake
ndometrial tissue unreceptive to implantation.

etrium of
ed patient



, the endometrium progresses through
ative phase stimulated by estrogen and a
phase stimulated by progesterone.
e secretory phase the endometrium is
to the fertilized ovum.

Endometrium produced
by Norinyl-1



When Norinyl-1 is administered its progestogen component—norethindrone—accelerates the secretory phase and suppresses glandular and vascular development.

new Norinyl-1® tablets
(norethindrone 1mg. & mestranol 0.05mg.)

e for contraindications, precautions, side effects and dosage.

effective fertility control
on half the previous dosage

maintains ratio
of the established
norethindrone/mestranol
combination

lower cost

new Norinyl®

(norethindrone 1mg. c̄ mestranol 0.05mg.) tablet

Reduction of oral contraceptive dosage to lowest effective le become a well-accepted principle of conservative medical In keeping with this view, Norinyl is now available in a new in which *both* norethindrone and mestranol are reduced 50 Studies show that Norinyl-1 achieves fertility control with o mg. of combined progestogen and estrogen per tablet.

Norethindrone was first reported for use as a progestational human beings in 1955. Norethindrone 2 mg. with mestranol 0.1 an oral contraceptive, is currently in use by over 2,000,000 Clinical experience now establishes that Norinyl-1 also ampl the criteria of reliability and safety.*

*Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965.

PRESCRIBING INFORMATION

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of Norinyl-1 in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with Norinyl-1. Therefore, if such tests are abnormal in a patient taking Norinyl-1, it is recommended that they be repeated after the drug has been withdrawn for 2 months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibroids may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac, or renal dysfunction, require careful observation. 5. Although a cause and effect relationship has not been established, Norinyl-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, as in all cases of irregular bleeding *per vaginam*, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged Norinyl-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Norinyl-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. A cause and effect relationship has not been demonstrated. 11. Because of the effects of estrogens on epiphyseal closure, Norinyl-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask the onset of the climacteric. 13. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma, breast changes (tenderness, enlargement and secretion), loss of scalp hair, change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, erythema multiforme, erythema nodosum, hemorrhagic eruption, migraine, rash (allergic), itching, rise in blood pressure in susceptible individuals, mental depression.

The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has not been established: thrombophlebitis, pulmonary embolism, neuroocular lesions.

The following laboratory results may be altered by the use of oral contra creased bromsulphalein retention hepatic function tests, coagulatio crease in prothrombin, factors VII, X), thyroid function (increase in Pl nol extractable protein-bound iodi crease in T^3 values), metapyrone te diol determination.

Other side effects reported to ha in association with use of this dr ness, hirsutism, pains in legs, back abdomen, dysuria, drowsiness, charge, libido increased and decr tions, hypermenorrhea, hypo increased appetite, G.U. infectio veins, abdominal fullness, acne nervousness, allergies, blurred vis eyes, and itching in eyes. *For comp data, see package insert.*

Dosage and Administration: 1. O Norinyl-1 is administered orally f beginning on day 5 of the men (Count day 1 of the cycle as the menstrual bleeding.) Repeat this d ule for each cycle. 2. If no mens occurs after a cycle of treatment (2 which patient adhered to the sche tient must be instructed to resume Norinyl-1 tablets 7 days after the day course was completed. For exc last pill of a previous cycle had be a Sunday, then a new cycle of treat begin on the following Sunday. 3. partum woman, it is recommend first cycle of treatment should beg of the first menstrual cycle. Howev should not be administered during

Availability: Norinyl-1 (norethind with mestranol 0.05 mg.)—Dispense 60 and bottles of 250 tablets.

norethindrone — an original steroid

SYNTEX

LABORATORIES INC., PALO ALTO



in digestive disorders:

B and C vitamins aid therapy. Nausea, vomiting, and severe diarrhea may seriously interfere with the digestion and absorption of nutrients. STRESSCAPS capsules, containing therapeutic quantities of vitamins B and C, may help meet the needs of these patients. In digestive disorders, as in many stress conditions, STRESSCAPS vitamins aid therapy.



Stresscaps®

Stress Formula Vitamins Lederle

FOR PROFESSIONAL RECOMMENDATION ONLY

Each capsule contains:	
Vitamin B_1 (as Thiamine Mononitrate)	10 mg
Vitamin B_2 (Riboflavin)	10 mg
Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Vitamin C (Ascorbic Acid)	300 mg
Niacinamide	100 mg
Calcium Pantothenate	20 mg

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

692—6—3943

Lederle

Winthrop

announces

a breakthrough in the control of pain

Talwin®

brand of

pentazocine

(as lactate)

a potent, injectable non-narcotic

For every physician who has ever prescribed morphine

Talwin is the new potent non-narcotic injectable analgesic which is indicated for relief of all types and degrees of pain in acute and chronic disorders. Talwin 30 mg. is usually as effective an analgesic as morphine 10 mg. or meperidine 75 to 100 mg., but needs no narcotics controls. The duration of action of Talwin may sometimes be less than that of morphine.

Talwin is relatively free from adverse effe morphine, such as constipation, urinary rete or severe respiratory depression.

It has been used, in varying dosages, in 12,000 patients for relief of pain of medica orders, of active labor and postoperative also for preoperative or preanesthetic medic and as an adjunct to anesthesia.

A brochure incorporating analyzed information on Talwin is available. The completeness of the information will permit you to evaluate the role Talwin can play in your practice.

You can depend on Talwin to relieve pain:

WHATEVER the intensity of the pain
the cause of the pain
the site* of the pain
the duration of the pain
the chronicity of the pain
the age† of the patient

Talwin does not require a narcotics prescript

The World Health Organization Expert Commit Dependence-Producing Drugs concluded that ". was no need at this time for narcotics control of zocine [Talwin] internationally or nationally." *Tech. Rep. Ser.*, No. 343, 1966, p. 6.)

It is our sincere belief that the discovery of Tal Winthrop Laboratories will be of great value to y your patients for whom you may have to presc potent analgesic.

*Talwin should not be used for patients with increased intracranial head injury or pathologic brain conditions.

†Until sufficient experience is gained, it should not be administered t under 12 years of age.

win—brand of pentazocine (as lactate)

aindications: *Increased Intracranial Pressure, Head Injury, hologic Brain Conditions in which clouding of sensorium is irable.* Talwin (brand of pentazocine) should not be adminis- in these cases, since drug-induced sedation, dizziness, nausea, piratory depression could be misleading.

utions: *Pregnancy.* No teratogenic or embryotoxic effects utable to the use of Talwin have been seen in extensive repro- e studies in animals; however, like all new drugs, Talwin l be given with caution to pregnant women. A large number ients in labor have received the drug with no adverse reac- other than those that occur with commonly used strong sics. However, as with other strong analgesics, Talwin should ed with caution in women delivering premature infants.

latory Patients. Since sedation, dizziness, and occasional ria have been noted, ambulatory patients should be warned operate machinery, drive cars, or unnecessarily expose them- to hazards.

in Respiratory Conditions. The possibility that Talwin (brand ntazocine) may cause respiratory depression should be con- d in treatment of patients with bronchial asthma. Talwin l of pentazocine) should be administered only with caution n low dosage to patients with respiratory depression (e.g., other medication, uremia, or severe infection), obstructive atory conditions, or cyanosis.

nts Dependent on Narcotics. Because Talwin is a narcotic- onist, patients dependent on narcotics and receiving Talwin ccasionally experience certain withdrawal symptoms. Talwin l be given with special caution to such patients. It has been ed that some patients previously given narcotic-analgesics e month or longer had mild withdrawal symptoms when the vas replaced with the analgesic, Talwin. After a short period ustment the subjects were usually able and willing to con- aking Talwin, and relief of pain was satisfactory.

dicted Patients Receiving Narcotics. Symptoms believed to icative of antagonism to the opiate may be observed rarely dministration of Talwin to patients receiving opiates for a ime. Intolerance or untoward reactions are seldom observed dministration of Talwin to patients who have received single or who have had limited exposure to narcotics.

ed Renal or Hepatic Function. Although laboratory tests e ot indicated that Talwin (brand of pentazocine) causes or es renal or hepatic impairment, the drug should be adminis- vith caution to patients with such impairment. Extensive isease appears to predispose to greater side effects (e.g., l apprehension, anxiety, dizziness, sleepiness) from the usual dose, and may be the result of decreased metabolism of the y the liver.

rdial Infarction. As with all drugs, Talwin (brand of penta- should be used with caution in patients with myocardial on who have nausea or vomiting.

Surgery. Until further experience is gained with the effects in on the sphincter of Oddi, the drug should be used with in patients about to undergo surgery of the biliary tract.

Effects: Talwin is relatively free from the undesirable side ssociated with morphine, such as constipation, urinary re- or severe respiratory depression. Furthermore, Talwin s less nausea, vomiting, and diaphoresis than meperidine.

12,000 patients who received Talwin intramuscularly, sub- sly, or intravenously, nausea, the most frequent adverse curred in approximately 5.0 per cent. In decreasing order rence were vertigo, dizziness or lightheadedness; vomiting; horia. Respiratory depression was reported as an adverse in 1.0 per cent.

dence of each of the other adverse effects was well below ent: constipation, circulatory depression, diaphoresis, uri- ention, alteration in mood (nervousness, apprehension, n, floating feeling), hypertension, sting on injection, head- ache, dry mouth, flushed skin including plethora, altered uterine contractions during labor, dermatitis including pruritus, dreams, paresthesia, and dyspnea occurred rarely after administration of Talwin (brand of pentazocine). Furthermore, each of the following adverse reactions occurred in less than 0.1 per cent: tachycardia, visual disturbance (blurred vision, diplopia and nystagmus), hallucinations, disorientation, weakness or faintness, muscle tremor, chills, allergic reactions including edema of the face, taste alteration, insomnia, diarrhea, cramps, and miosis; laryngospasm in one patient.

Talwin has not produced severe respiratory embarrassment in adults (never apnea), even with large amounts. A small number of newborn infants whose mothers received Talwin during labor had transient apnea. The incidence of temporary diminution in the rate or strength of uterine contractions is low after administration of Talwin, similar to that following meperidine hydrochloride. (In reporting no interference with normal labor in patients receiving Talwin, one investigator further stated that the drug may increase uterine activity.) Generally, no significant fetal heart rate change occurs.

Laboratory tests of blood and of liver and kidney functions have revealed no significant abnormalities. A minimum and probably insignificant increase in the per cent of eosinophils in peripheral blood counts and bone marrow occurred occasionally.

Talwin is well tolerated by patients with diabetes mellitus, and no changes in insulin requirements have been observed.

Dosage and Administration: *Adults, Excluding Patients in Labor.* Average recommended single parenteral dose is 30 mg., by intramuscular, subcutaneous, or intravenous route; may be repeated every three to four hours. Pain has been relieved in most patients with not more than three doses daily. Infrequently, selected patients have received single doses as high as 60 mg. *Patients in Labor.* A single, intramuscular 30 mg. dose has been most commonly administered. An intravenous 20 mg. dose has given adequate pain relief to some patients in labor when contractions become regular, and this dose may be given two or three times at two- to three-hour intervals, as needed.

Children Under 12 Years of Age. Since clinical experience in children under twelve years of age is limited, the use of Talwin (brand of pentazocine) in this age group is not recommended.

Duration of Therapy. Patients with chronic pain who received Talwin for prolonged periods (e.g., over 300 days) experienced no withdrawal symptoms even when administration was stopped abruptly; furthermore, there was no tolerance to the analgesic effect.

CAUTION. Talwin should not be mixed in the same syringe with soluble barbiturates because precipitation will occur.

Treatment of Overdosage or Respiratory Depression. Talwin has not produced apnea or severe respiratory embarrassment in adults, even in large doses. Occasionally, however, moderate respiratory depression may occur. Means of maintaining proper oxygenation should be available in case of overdosage or respiratory depression, and methylphenidate (Ritalin®) should be administered parenterally. The usual narcotic-antagonists, such as nalorphine, are not effective respiratory stimulants for depression due to Talwin.

How Supplied: *Ampuls of 1 ml.*, containing Talwin® (pentazocine) as lactate equivalent to 30 mg. base and 2.8 mg. sodium chloride, in Water for Injection. Boxes of 10, 25, and 100.

Multiple dose vials of 10 ml., each 1 ml. containing Talwin (pentazocine) as lactate equivalent to 30 mg. base, 2 mg. acetone sodium bisulfite, 1.5 mg. sodium chloride, and 1 mg. methylparaben as preservative, in Water for Injection. Boxes of 1.

The pH of Talwin solutions is adjusted between 4 and 5 with lactic acid and sodium hydroxide.

Winthrop

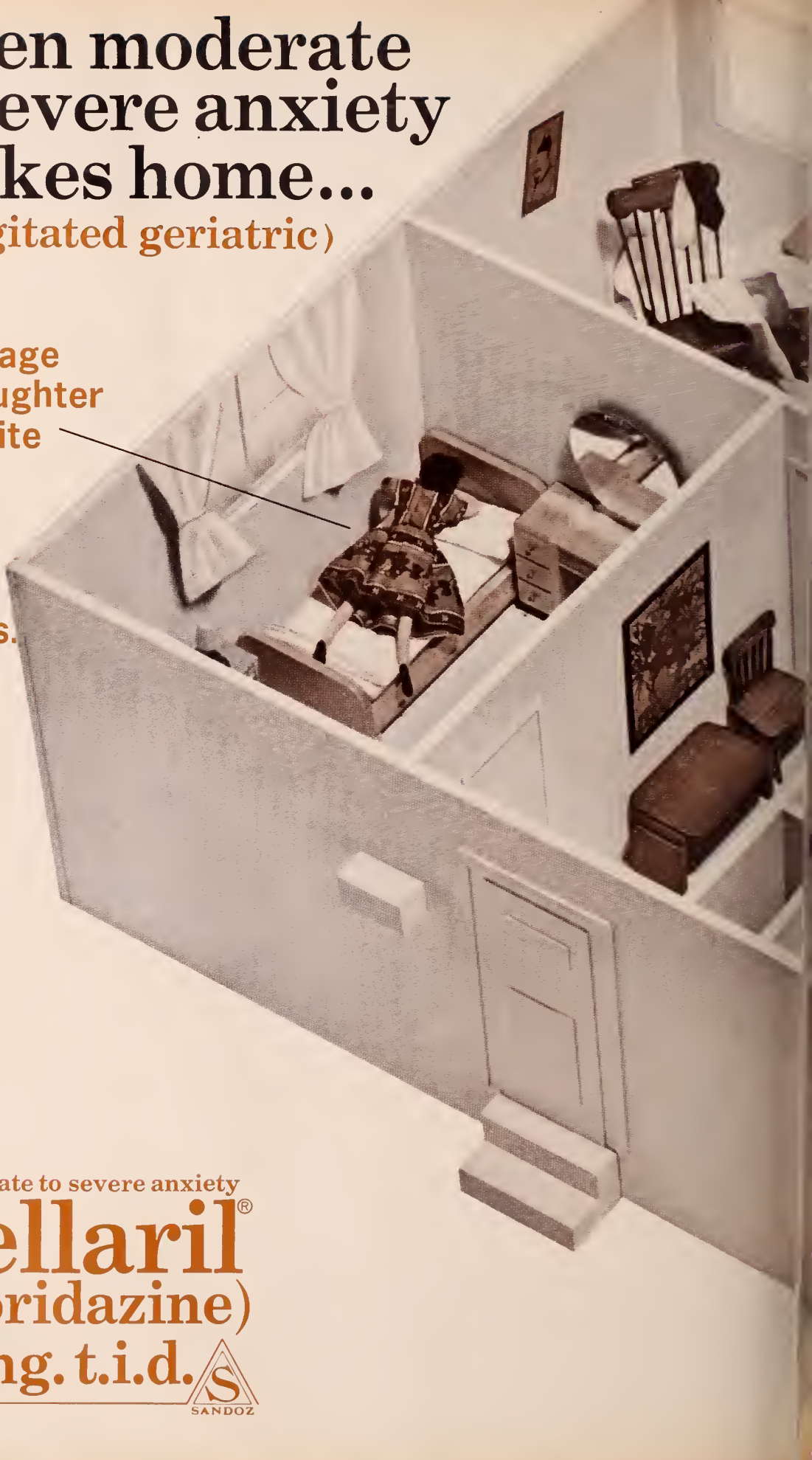
Winthrop Laboratories, New York, N.Y. 10016

(1150M)

When moderate to severe anxiety strikes home...

(the agitated geriatric)

His teen-age granddaughter won't invite friends home because of his outbursts.



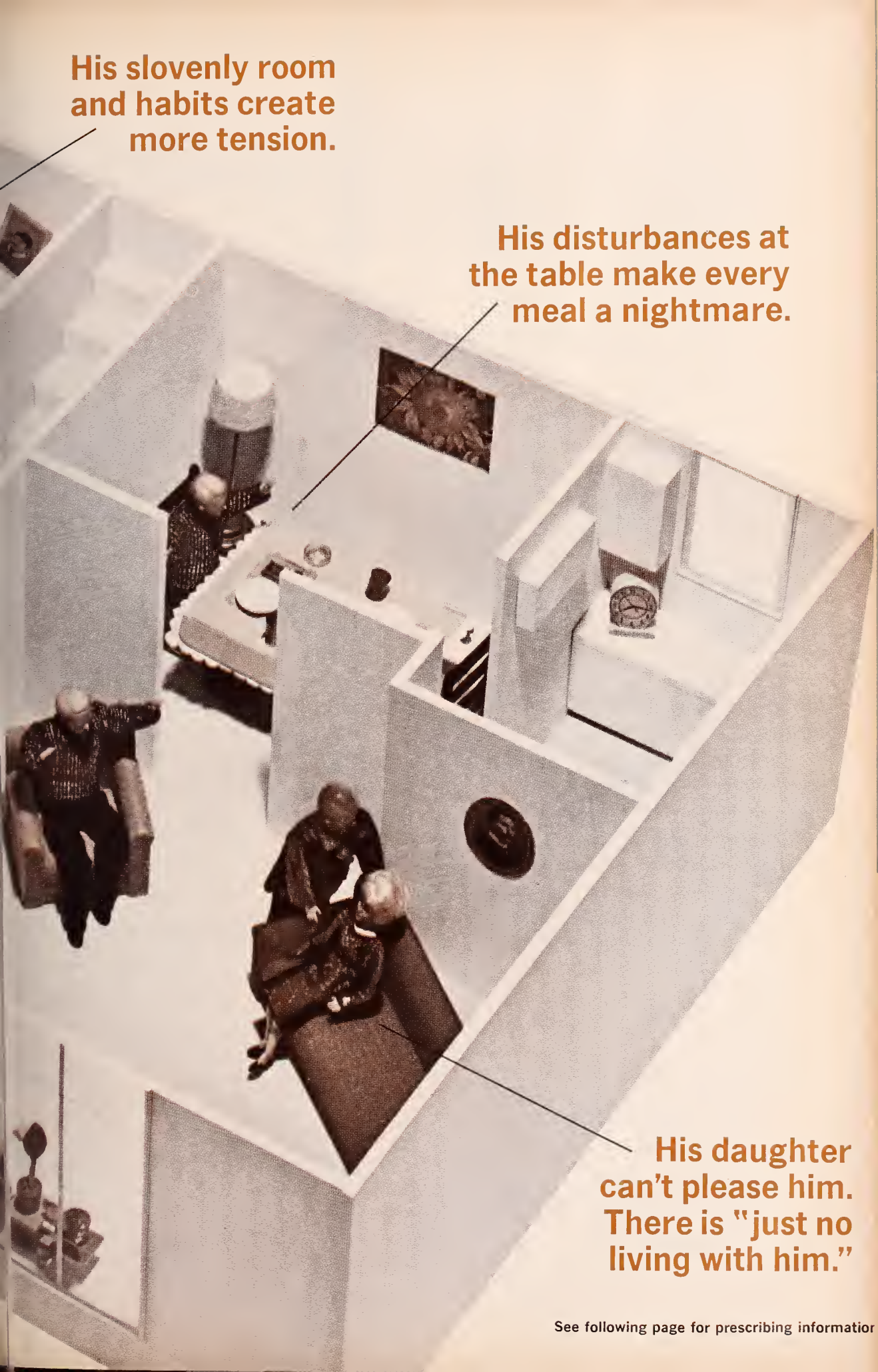
for moderate to severe anxiety

Mellaril®

(thioridazine)

25 mg. t.i.d.

SANDOZ



See following page for prescribing information

When moderate to severe anxiety strikes home...

Anxiety that *seriously interferes* with the individual's performance at work, at home, or in the community may be regarded as *moderate to severe* in degree.

Mellaril often recommends itself to the treatment of moderate to severe anxiety because it

- helps control the most frequent symptoms: marked tension, agitation, apprehension, restlessness, hypermotility
- often alleviates anxiety-induced somatic complaints
- frequently helps strengthen emotional resources
- helps the patient maintain realistic contact with environment, closer harmony with family

Thus, when you consider the anxiety moderate to severe... consider Mellaril.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

Before prescribing, see package insert for full product information.

for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

SANDOZ

mudrane

for

- EMPHYSEMA
- ASTHMA
- CHRONIC BRONCHITIS
- BRONCHIECTASIS

The fast-disintegrating uncoated tablet gives relief in 15 minutes

Each tablet contains:

Potassium Iodide	195 m
Aminophylline	130 m
Phenobarbital, Caution: May be habit forming...	21 m
Ephedrine HCl	16 m

FEDERAL LAW PROHIBITS
DISPENSING WITHOUT PRESCRIPTION

Precautions: Usual for aminophylline-ephedri phenobarbital. Iodides may cause nausea, long u may cause goiter. Discontinue if symptoms iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package ider cal to Mudrane—*except*—100 mg. glyceryl guaiacol. replaces the potassium iodide. The value of Mudra cannot be enjoyed by a small group in which K.I. contraindicated. Mudrane GG is prepared for this gro

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls equivalent to one Mudrane GG tablet. Dosage adjus to age and weight of child. Mudrane GG Elixir is pediatric patients and those who think they cannot sw low tablets. Dispensed in pint and half gallon botti

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Manufacturers of ethical pharmaceuticals since 1856

What's all the fuss about bactericidal?

The ultimate aim in antibiotic therapy is to contain the bacterial colony and eliminate infection. Both 'cidal' agents and bacteriostatic DECLOMYCIN achieve this goal. DECLOMYCIN inhibits susceptible pathogens by stopping their growth; cidal agents affect the pathogens only while they are growing.

Though the two mechanisms differ, the end result is the same—containment of the infecting organism. *However, a very important attribute of any antibiotic is its potency against a broad range of pathogens.* DECLOMYCIN not only offers broad-spectrum potency, but high serum and tissue levels with persistent activity against tetracycline-sensitive organisms. Therapeutic benefits continue for 1-2 days after dosage stops to help prevent relapsing infection.

These are the reasons why so many doctors make DECLOMYCIN their basic broad-spectrum antibiotic. At last count, one billion doses had been administered since its introduction, and the number keeps rapidly growing.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Lederle

Prescribing information on next page.

For a wide range of everyda
infections—respiratory,
urinary tract and others—
in the young and aged—the
acutely or chronically ill.

True
broad spectrur

DECLOMYCIN Demethylchlortetracycline shou
equally or more effective than other tetracyclines
the offending organisms are tetracycline-sensitive.

Contraindication: History of hypersensitivity to dem
chlortetracycline.

Warning—In renal impairment, usual doses may l
excessive accumulation and liver toxicity. Under
conditions, lower than usual doses are indicated,
therapy is prolonged, serum level determinations n
advisable. A photodynamic reaction to natural or
cial sunlight has been observed. Small amounts o
and short exposure may produce an exaggerate
burn reaction which may range from erythema to
skin manifestations. In a smaller proportion,
allergic reactions have been reported. Patients
avoid direct exposure to sunlight and discontinue c
the first evidence of skin discomfort. Necessary
quent courses of treatment with tetracyclines sho
carefully observed.

Precautions—Overgrowth of nonsusceptible orga
may occur. Constant observation is essential. If n
fections appear, appropriate measures should be
In infants, increased intracranial pressure with b
fontanels has been observed. All signs and sym
have disappeared rapidly upon cessation of trea

Side Effects—Gastrointestinal system—anorexia, n
vomiting, diarrhea, stomatitis, glossitis, enterocolit
ritus ani. Skin—maculopapular and erythematous r
A rare case of exfoliative dermatitis has been re
Photosensitivity; onycholysis and discoloration
nails (rare). Kidney—rise in BUN, apparently dc
lated. Hypersensitivity reactions—urticaria, angion
edema, anaphylaxis. Teeth — dental staining (
brown) in children of mothers given this drug duri
latter half of pregnancy, and in children given th
during the neonatal period, infancy and early chil
Enamel hypoplasia has been seen in a few childc
adverse reaction or idiosyncrasy occurs discontinu
ication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 3
b.i.d. Should be given 1 hour before or 2 hour
meals, since absorption is impaired by the concc
administration of high calcium content drugs, foo
some dairy products. Treatment of streptococcal
tions should continue for 10 days, even though
toms have subsided.

Capsules: 150 mg; **Tablets:** film coated, 300 m
mg, and 75 mg of demethylchlortetracycline HCl.

DECLOMYCI
DEMETHYLCHLORTETRACYCI

LEDERLE LABORATORIES, A Division of
American Cyanamid Company, Pearl River, Ne

Lederle



"When I couldn't even smell corned beef and cabbage,
I decided it was time for you, Doc."

Maybe he doesn't know when he's well off. But you might want to prescribe long-acting Novahistine LP anyway.

Two tablets in the morning and two in the evening will usually provide day and night relief by helping to clear congested air passages for normal, free breathing. Novahistine LP is formulated to provide continuous therapeutic effect for 8 to 12 hours. The decongestant ingredients help restore normal mucus secretion and ciliary activity—physiologic defenses against infection of the respiratory tract.

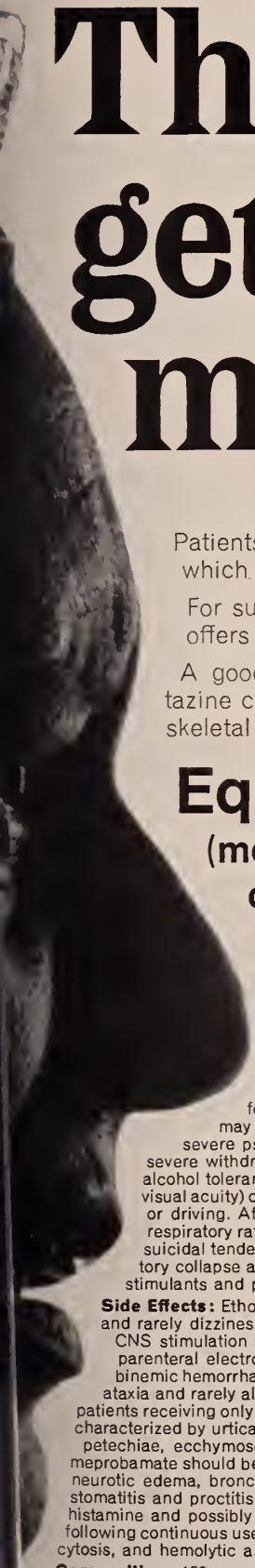
Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result. Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

NOVAHISTINE® LP

Dow **PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis



This pain is getting on my nerves.



Patients in pain often experience concomitant anxiety and tension, which may add to the burden of pain.

For such patients, you may want to prescribe a preparation that offers more than simple analgesia.

A good choice is often EQUAGESIC® (meprobamate and ethoheptazine citrate with aspirin). It helps relieve pain. And anxiety. And skeletal muscle spasm as related to pain or anxiety and tension.

Equagesic® TABLETS

(meprobamate and ethoheptazine citrate with aspirin)

Wyeth®

Contraindications: History of sensitivity or severe intolerance to aspirin or meprobamate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate may result in dependence or habituation in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics. Withdraw gradually after prolonged high dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, caution patients against operating machinery or driving. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with immediate gastric lavage and appropriate supportive therapy (CNS stimulants and pressor amines as indicated).

Side Effects: Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness. Overdosage may result in CNS depression (drowsiness and lightheadedness) or CNS stimulation and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]). Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically such as with epinephrine, antihistamine and possibly hydrocortisone. A few cases of leucopenia, usually transient, have been reported following continuous use. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa.

A MEDICAL-SURGICAL SYMPOSIUM
SPONSORED BY
SAINT BARNABAS HOSPITAL, NEW YORK CITY

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Burton L. Zohman

DECEMBER 15, 16, 17, 1967 THE PLAZA, N. Y. C.

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PHONE (212) CYpress 5-2000 EXT. 324

The AMBAR SCRAPBOOK of Obesity Oddities
FACT & LEGEND



GALLSTONES HAVE BEEN FOUND IN 60% OF PATIENTS WHO WEIGH MORE THAN 300 POUNDS. 45% HAVE DIABETES, AND 15-TO-20% HAVE HIGH BLOOD PRESSURE.

SOURCE: DUNCAN, G.G.: SCIENCE NEWS LETTER, 83:403 (JUNE 29) 1963.

NAPOLÉON BONAPARTE LOST THE BATTLE OF WATERLOO BECAUSE HE WAS TOO FAT!

ACCORDING TO THE NEW YORK TIMES OF APRIL 13, 1890, HE DEFEAT OCCURRED BECAUSE HE FAILED TO CHECK HIS NTELLIGENCE INFORMATION. "IT WAS A MATTER OF MERE NDOLENCE AND THIS INDOLENCE WAS CAUSED BY FAT."

OURCE: JAMA 186:65 (OCT. 5) 1963.



E BOOK **"PRAY YOUR WEIGHT AWAY"** URGES READERS TO K GOD TO HELP YOU LIKE EXERCISE" FOR 15 MINUTES A DAY.

IRCE: REV. C.W. SHEDD: NEW YORK, LIPPINCOTT, 1958.



DIET DROPOUTS ACCORDING TO DRS. SHIPMAN AND PLESSET "APPARENTLY NO DIETER SUCCEEDS WHO IS VERY ANXIOUS OR DEPRESSED."* THE AMBAR FORMULA PROVIDES **METHAMPHETAMINE** TO HELP **ELEVATE** THE **MOOD** AND **PHENOBARBITAL** TO HELP REDUCE **ANXIETY.**

*SOURCE: ARCHIVES OF GENERAL PSYCHIATRY 8:26 (JUNE 1963).

NTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

n Ambar Extentab before breakfast can el control most patients' appetite for up : hours. Methamphetamine, the appe- e uppressant, gently elevates mood and overcome dieting frustrations. Pheno- tal, the sedative in Ambar, controls irritability and ty...helps maintain a state of mental calm and equa- ry. Both work together to ease the tensions that erode e illpower during periods of dieting.

ls available: Ambar #1 Extentabs®—methamphetamine ochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warn- g may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220 A·H·ROBINS

Against these three major pathogens…



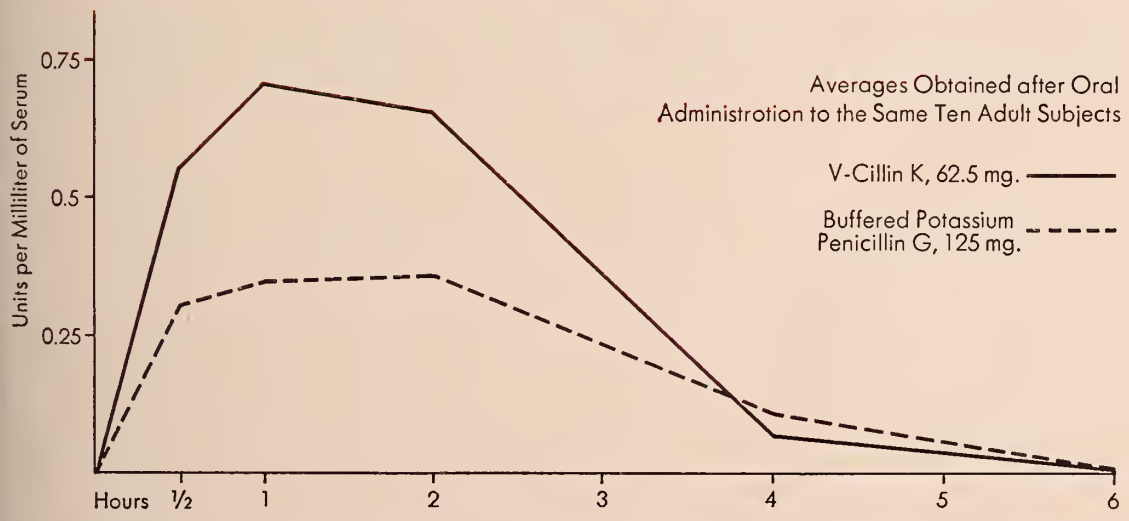
V-Cillin K® provides dependable oral antibacterial activity

because it combines a high degree of in-vitro activity...

Antibiotic	Stoph. Aureus (Penicillin-Sensitive) MIC (mcg./ml.) Median	Range	Streptococcus, Group A MIC (mcg./ml.) Median	Range	Diplococcus Pneumonioe MIC (mcg./ml.) Median	Range
Penicillin V	0.02	0.02-0.04	0.02	0.003-0.4	0.01	0.005-0.2
Penicillin G	0.02	0.005-1.6	0.005	0.002-0.2	0.02	0.01-0.1
Methicillin	1.6	0.4-6.3	0.2	0.1-0.4	0.2	0.1-1.6
Oxacillin	0.4	0.1-3.1	0.04	0.02-0.4	0.1	0.04-0.8
Cloxacillin	0.2	0.2-0.8	0.1	0.1-0.8	—	—
Nafcillin	0.4	0.2-0.8	0.04	0.02-0.1	0.02	0.02-0.2
Ampicillin	0.2	0.1-0.8	0.02	0.01-0.04	0.02	0.01-0.04

Adapted from Klein, J. O., and Finland, M.: New England J. Med., 269:1019, 1963.

with high blood levels, even in the presence of food



Adapted from Griffith, R. S., and Black, H. R.: Current Ther. Res., 6:253, 1964.

V-Cillin K®

Lilly 700867

Potassium Phenoxymethyl Penicillin

(See next page for prescribing informatic

New 500 mg. tablets...a more convenient way to give high do



Description: V-Cillin K is the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly). This chemically improved form combines acid stability with immediate solubility and rapid absorption. Higher serum levels are obtained more rapidly with this penicillin than with equal oral doses of penicillin G. The higher serum levels and acid stability of V-Cillin K make it a more dependable penicillin for oral use.

V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

Indications: V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Warnings: In rare instances, the use of penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin and in those with bronchial asthma or other allergies. Resuscitative drugs should be readily available for emergency administration. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for relief of immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly parenteral dosage schedules, frequent evaluation of the hematopoietic systems is recommended.

In suspected staphylococcus infections, proper labora (including sensitivity tests) should be performed.

The use of penicillin may be associated with the ov pencillin-insensitive organisms. In such cases, its administr be discontinued, and appropriate measures should be tak

Adverse Reactions: Although serious allergic reactions ar common with administration of oral penicillin than with in forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it does posse cant index of sensitization. The following hypersensitivit associated with the use of penicillin have been reported: ranging from maculopapular eruptions to exfoliative der caria; and reactions resembling serum sickness, including edema, arthralgia, and prostration. Severe and often fatal has occurred (see Warnings). Hemolytic anemia, leukope bocytopenia, and nephropathy are rarely observed side- are usually associated with high parenteral dosage.

Administration and Dosage: For Tablets V-Cillin K and fo Pediatric, the usual dosage ranges from 125 mg. (200,000 times a day to 500 mg. (800,000 units) every four hours. the daily dosage may be 50 mg. per Kg. of body weight three doses.

Beta-hemolytic streptococcus infections without assoc teremia may be treated with 200,000 to 400,0000 units th day. Therapy should be continued for a minimum of ten days development of rheumatic fever and/or other serious cor Dosage for routine streptococcus prophylaxis in patients wi of rheumatic fever or congenital heart disease may be 20 once or twice daily. When such patients undergo tonsillec extraction, or other minor surgery, the prophylactic dose 500,000 units every six hours given two days prior to surge two days postoperatively. If oral medication is not feasible of surgery, parenteral therapy should be considered. Mild ately severe pneumococcus pneumonia has been treated with 250 mg. every six hours.

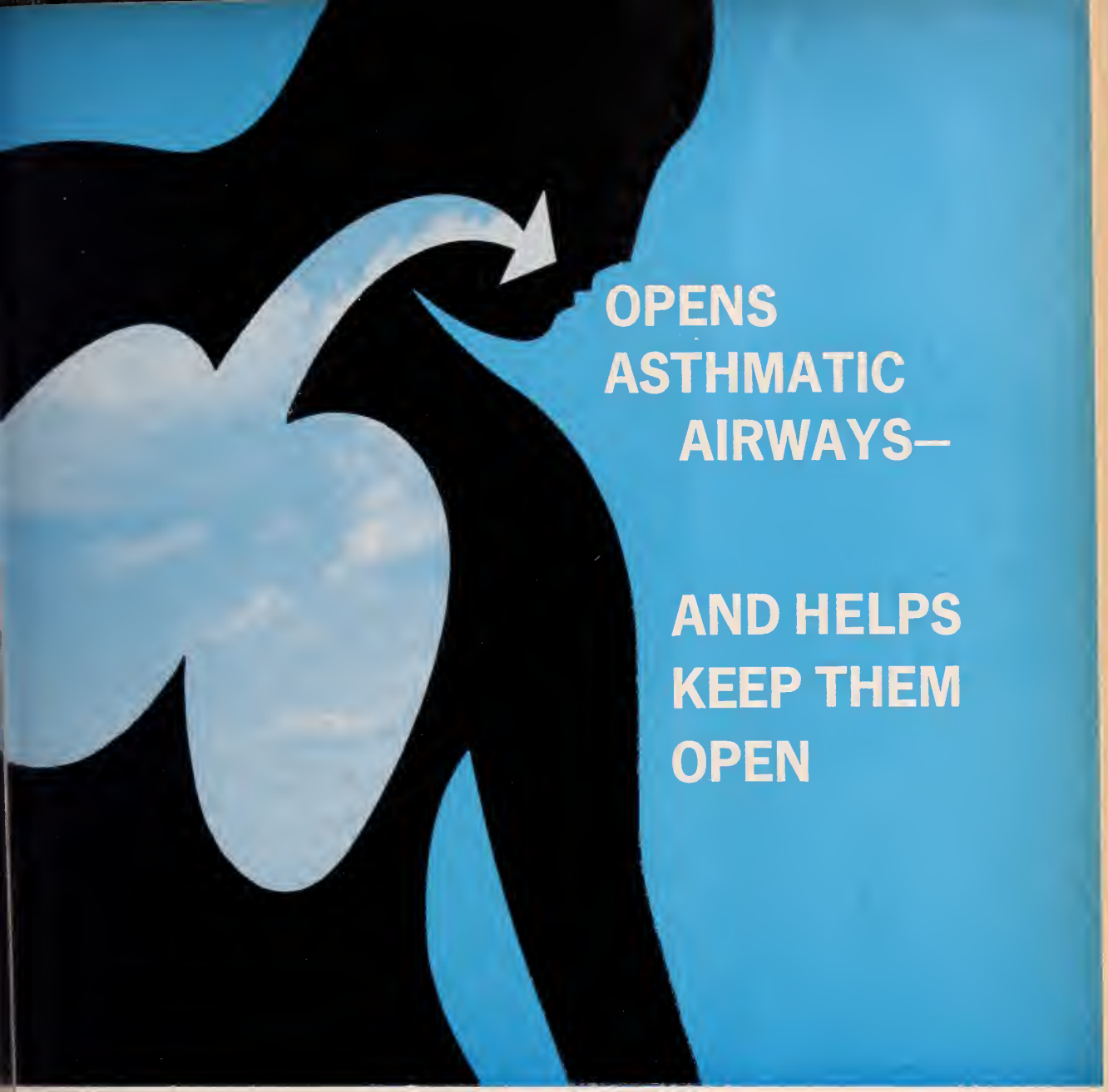
In staphylococcus infections, 400,000 units or more shou every six to eight hours in conjunction with indicated surg dures.

For gonorrhea in males, 500 mg. (800,000 units) every fou three doses may be employed; in females, 500 mg. every for six doses are recommended. Refractory infections genera to a second treatment three to four days following comple first. Treatment of gonorrhea with severe complications individualized, with prolonged and intensive treatment. Pati suspected lesion of syphilis should have a dark-field exam fore receiving penicillin and monthly serologic tests for a three months.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,00 bottles of 50 and 100; and 250 mg. (400,0000 units) an (800,000 units), in bottles of 24 and 100.

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 5 cc. of solution, in 40, 80, and 150-cc.-size packages.

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.



NUMA® DURA-TABS®

for *prolonged* aid to ventilation

Each Numa Dura-Tab provides:

theophylline	225 mg.
ephedrine HCl	50 mg.
butabarbital	25 mg.

(Warning: butabarbital may be habit-forming.)

Numa Dura-Tabs provide *prolonged* three-way action to ease breathing. Theophylline, a potent bronchodilator with minimal effect on the CNS, opens air passages and reduces bronchial spasm. Ephedrine HCl improves breathing capacity through its decongestant action. Butabarbital, a mild sedative, allays fear and apprehension.

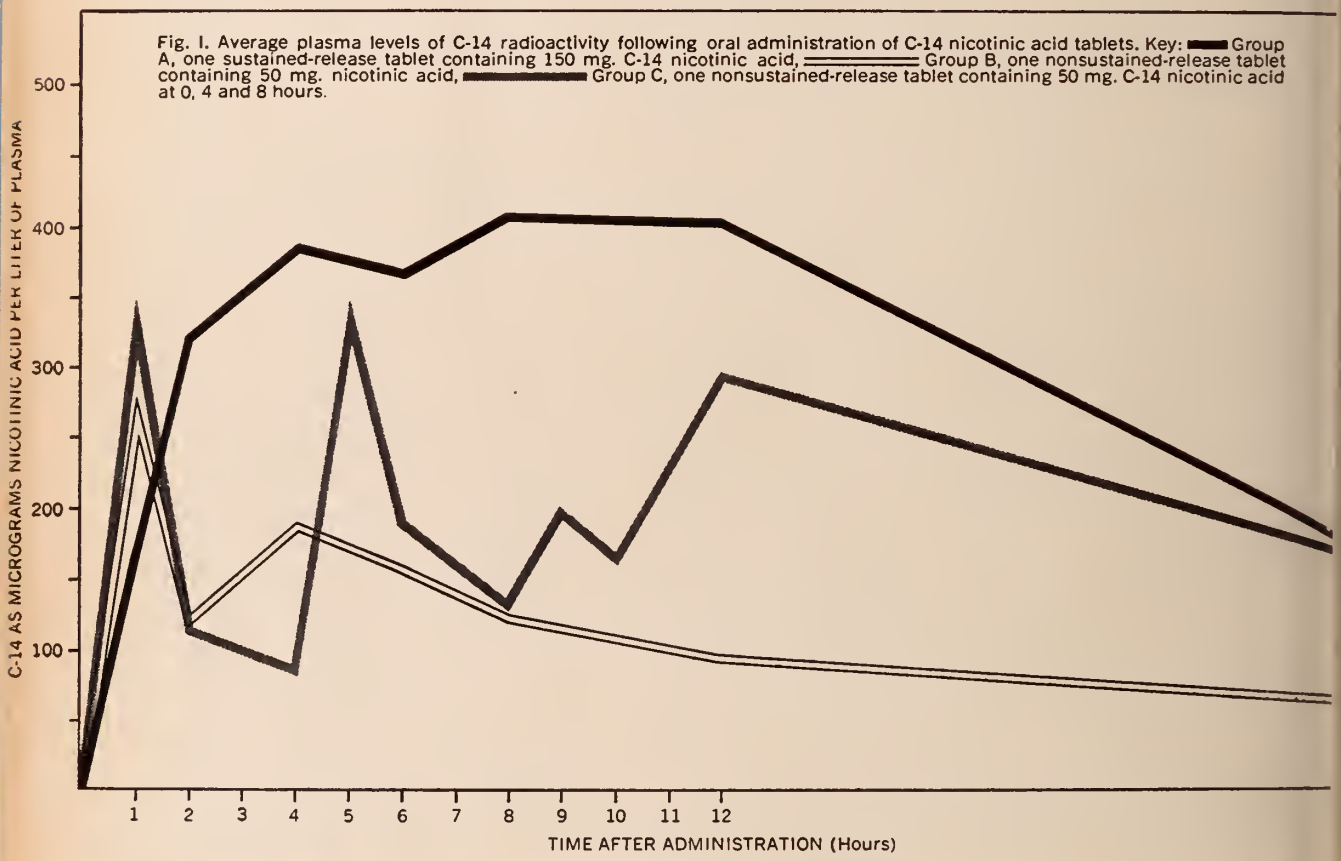
Dosage: One Numa Dura-Tab every 8 to 12 hours helps keep the asthmatic patient symptom-free all day/all night.

Precautions: Use with caution in cardiovascular or hyperthyroid disease, severe hypertension, circulatory collapse, prostatic hypertrophy, or glaucoma.

WYNN Pharmaceuticals, Inc. Phila., Pa. 19132 • Manufacturers of QUINAGLUTE® DURA-TABS®
(QUINIDINE GLUCONATE 5 gr.)

Sustained circulatory, respirato
and cerebral stimulation for t

Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▬▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.





(fewer absent doses by absent-minded patients)

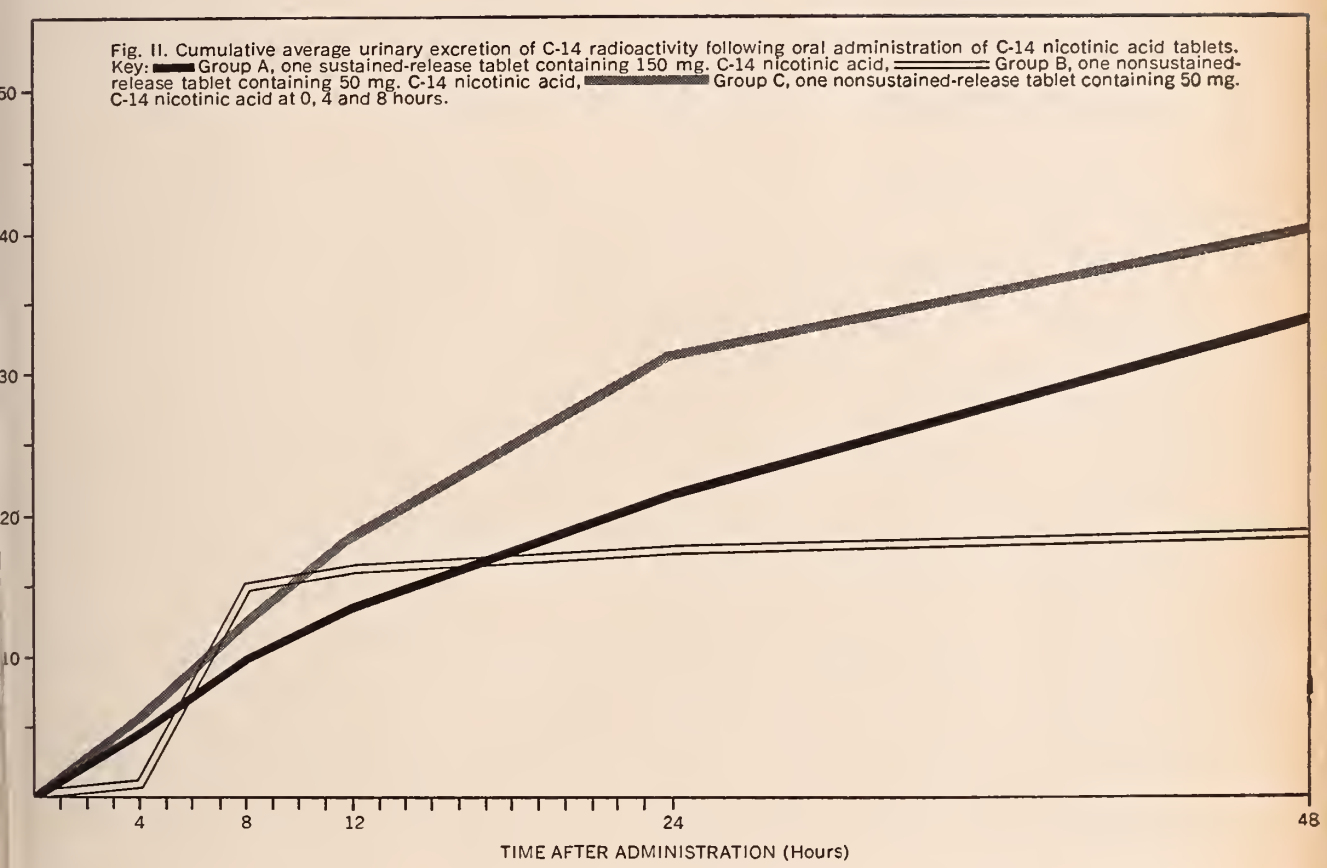
Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be co tinuous on a daily dose of only one Geroniazol TT ta let every 12 hours.

The gradual release of nicotinic acid in Geronia TT will provide the well-known peripheral vasodila tion needed in patients with deficient circulation a with a minimum amount (if any) of "flushing." Al cerebrovascular circulation is complemented by pe tylenetetrazol, long-established as a cerebral and r piratory stimulant.

Geroniazol TT improves the typical, unfortuna signs of senile confusion. Patients become more ale

ed and debilitated



confused and moody. Personal care, memory, tional stability, social attention improve. Fatigue, thy and irritability are reduced.

prescription for 100 tablets of Geroniazol TT will nit your patients to enjoy the benefits of time-onged nicotinic acid/pentylenetetrazol therapy, n economical price. Dosage is only one tablet every ours.

traindications: There are no known contraindica-s.

autions: Exercise caution when treating patients a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

"First with the Retro-Steroids"
PHILIPS ROXANE LABORATORIES
Division of Philips Roxane, Inc., Columbus, Ohio
A Subsidiary of Philips Electronics and Pharmaceutical Industries Corp.

Geroniazol® TT

nicotinic acid 150 mg., pentylenetetrazol 300 mg.
Tempotrol® Time Controlled Tablet



Photo professionally pose

Mike expects a penicillin injection. He's about to be pleasantly surprised.

His physician is going to prescribe an oral penicillin —PEN•VEE® K (potassium phenoxymethyl penicillin). It's usually so rapidly and completely absorbed that therapeutic serum levels are produced in 15 to 30 minutes. Higher serum levels generally last longer than with oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.

Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.

Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.

Precautions: In suspected staphylococcal infections, perform proper laborator studies including sensitivity tests. If overgrowth of nonsusceptible organism occurs (constant observation is essential), discontinue penicillin and take appro priate measures. Whenever allergic reactions occur, withdraw penicillin unles condition being treated is considered life threatening and amenable only t penicillin. Penicillin may delay or prevent appearance of primary syphiliti lesions. Gonorrhea patients suspected of concurrent syphilis should be teste serologically for at least 3 months. When lesions of primary syphilis are sus pected, dark-field examination should precede use of penicillin. Treat beta hemolytic streptococcal infections with full therapeutic dosage for at least 1 days to prevent rheumatic fever or glomerulonephritis. In staphylococca infections, perform surgery as indicated.

Adverse Reactions (Penicillin has significant index of sensitization): Ski rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria serum sickness-like reactions, including chills, fever, edema, arthralgia and pros tration. Severe and often fatal anaphylaxis has been reported (see "Warnings").

Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 50 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,00 units) per 5 cc.

ORAL **PEN·VEE® K**

(potassium phenoxymethyl penicillin) Wyeth

DOCTOR,

Here is the expanded Abbott anorectic program designed to meet the individual needs of your overweight patients.



THE PRODUCT

ABBOT
ANORECTI
PROGRA

DESOXYN® Gradumet®
METHAMPHETAMINE HYDROCHLORIDE IN LONG-RELEASE DOSE FORM

5 mg. 10 mg. 15 mg.

DESBUTAL® 10 Gradumet
10 mg. METHAMPHETAMINE HYDROCHLORIDE, 60 mg. SODIUM PENTOBARBITAL

FRONT SIDE

DESBUTAL 15 Gradumet
15 mg. METHAMPHETAMINE HYDROCHLORIDE, 90 mg. SODIUM PENTOBARBITAL

FRONT SIDE

MOOD ELEVATION

DESOXYN Gradumet
Smooth appetite control plus mood elevation

Typically, the obese patient is a repeat dieter. And with each failure, the task looks more hopeless. Therefore, it is often just as important to lift the mood as to curb the appetite. Desoxyn Gradumet does just that. It gently elevates and sustains the mood. And no other product—amphetamine or non-amphetamine—is more effective in suppressing appetite.

DESBUTAL Gradumet
For patients who can't take plain amphetamine

Desbutal Gradumet contains 2 drugs, each in it own tablet section, combined back to back to for a single tablet. One section contains Desoxyn t suppress the appetite and lift the mood; the oth contains Nembutal® (pentobarbital) to soothe th patient and counteract any excessive stimulatio The drugs are released in an effective dosage rati throughout the day.

CONTROLLED-RELEASE

HOW IT DIFFERS FROM LONG-RELEASE

The Gradumet is made up of thousands of interconnecting channels, much like a sponge. These channels—filled with a drug—end at the outer surface of the tablet. When fluid comes in contact with the Gradumet, the drug in the outer ends of the channels dissolves. As the fluid makes its way up the channels, there is a continuous release of medication.

Since the rate of release is rigidly determined by the size and number of channels, the Gradumet is able to provide controlled-release as well as long-release. Patients get a measured amount of medication, moment by moment, throughout the day—from a single oral dose.



THIS IS A RELEASE YOU CAN COUNT ON

THE PROGRAM

WEIGHT CONTROL BOOKLET



To help your obese patients understand why they are overweight—and what they can do about it—Abbott has a booklet called "The Secret of Controlling Your Weight." *It is available to your patients only through you.*

Here is a partial list of the topics covered:

- Why you are overweight
- Rewards of weight reducing
- Balanced meals
- Helpful hints
- Hunger between meals
- Snacks
- Weekly weighings
- Exercise
- Holidays, vacations, special events
- Leanness and longevity

Each topic is covered on one page in simple and easy-to-understand language. At the back of the booklet, there is a list of 160 foods showing their caloric content.

FOOD DIARY

The Food Diary is designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing everything down that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.

This booklet also lists the caloric content of 160 foods.



See Brief Summary on next page.

THE PRICE

ABB
ANOREC
PROGR

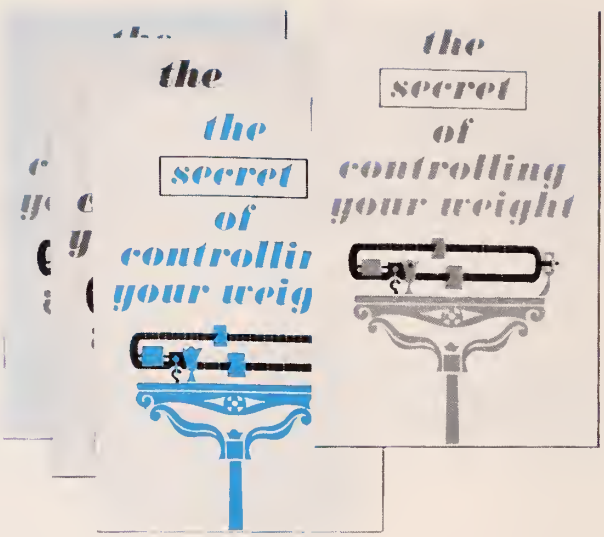
ECONOMY

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

Desoxyn Gradumet and Desbut Gradumet are so reasonably price that patients in many cases sav enough (compared to other leadir long-release anoretics) to get fi weeks of medication for the pric of four.

FREE SUPPLIES





There are four weight control booklets, each with the same text, but with a different sample in the back of the booklet to meet your individual patient's needs. You have your choice of Desoxyn Gradumet in 10 mg. or 15 mg. strengths as well as Desbutal 10 Gradumet and Desbutal 15 Gradumet. The Food Diary is the same for all of the weight control booklets.

Your Abbott man will be happy to supply you with booklets. Just ask him.

CONTRAINDICATIONS: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

PRECAUTIONS, SIDE EFFECTS: Observe ca tion in patients with hypertension, cardiovascu disease, hyperthyroidism, old age, or those sensiti to sympathomimetic drugs. Prolonged usage m lead to tolerance or psychic dependence. Care supervision is necessary to avoid chronic intoxic tion and addiction.

Amphetamine side effects such as a headache, e citement, agitation, palpitation or cardiac arrhythn usually may be controlled by reducing the do Paradoxically-induced depression is an indicati to withdraw the drug. Pentobarbital (in Desbut may cause skin rash. Nervousness or excessive sedation with Desbutal is usually transient.

701069

Gradumet—Long-release dose form, Abbott: U.S. Pat. No. 2,987,445.



THE FLAME THAT COOLS

Gas air conditioning's inherent low operating costs together with Public Service's *special low rate* during the warm weather months make it highly economical for almost all commercial and industrial applications. And our exceptional guarantee — two full years of free parts and service following the installation of a direct-fired gas air conditioning unit — ends maintenance worries. But where gas cooling really shines is in performance . . . the way it quickly responds with refreshing coolness even during the hottest, stickiest days . . . the way you can always depend on gas air conditioning to perform quietly and with maximum efficiency. Get all the facts about the flame that cools. Simply call your local Public Service office.

PUBLIC SERVICE ELECTRIC AND GAS COMPANY

easy does it!

tear, moisten, compare–that's all!



EDITORIALS

The *Hope* Means Hope

Dr. Abe Feuer told a reporter in his hometown that his two months aboard the S.S. *Hope* in Cartagena, Colombia, had been "one of the most rewarding experiences in my life." "Without any question," Dr. Feuer said, "there are more lasting friendships and gratitude resulting from a ten-month visit from the *Hope* than any other kind of visit to a foreign country. I am sure that if many such ships existed instead of just one, the foreign nations throughout the world would have a much higher opinion of us."

Dr. Feuer's reaction is typical of those who see this work first-hand. Now in its seventh year, the famed white hospital ship has woven itself into the legend of seven nations on three continents. The lives of more than one million people in developing nations have been touched by *Hope*. The level of medical practice in these countries is significantly higher because of the ship's visit. The S.S. *Hope* first took to sea in 1960. The maiden voyage to Indonesia and South Vietnam put the world spotlight on American medicine and brought wide acclaim to the volunteer American physicians, dentists, nurses, and technologists aboard. Further testimonials were gathered on the next voyage, to Peru. An ice-cold reception of the ship was contrasted with farewell ceremonies 10 months later which drew 45,000 grateful Peruvians to the waterfront.

Since then, *Hope* has conducted medical teaching-treatment missions to Ecuador, Guinea, Nicaragua, and, this year, Colombia. Next year, *Hope* will visit Ceylon, marking her first return to Asia since the maiden voyage. Its principal objective is to bring the technics of American medicine to the people of developing nations. Dr. Williams B. Walsh, the project's founder and President, reasoned from the beginning that treatment alone would not meet any long-range need of emerging nations. Teaching is the key and, in each country, *Hope* leaves behind a reservoir of knowledge.

Goodwill and knowledge are the legacies of *Hope*. A reporter recently interviewed Dr. Robert Wochos on his return from volunteer service in Colombia. Dr. Wochos said, in part:

"Few projects today offer a service without asking anything. Project *Hope* is free of demands, free of politics. We don't ask the Colombians to buy our wheat or to vote for us. Some people were suspicious at first. But once they know us, the S.S. *Hope* does more good and makes more of a social impact than many ships filled with dried milk and cereal."

The Times of Indonesia said: "The East forgets many things; but never, never loses its reverence for a teacher. Those on the *Hope* will linger long in our memory."

Project *Hope* is a private, non-profit foundation. It is supported by American industry and individuals who each year contribute the $5 million needed to operate the ship and shore stations. *Hope* deserves the continued, wholehearted support of American medicine. When asked to give, give generously

Our Unique Helping Hand Society

The Society for the Relief of Widows and Orphans of Medical Men is in position to provide assistance in many ways to widows of deceased members who may be in need. If any physician knows of a widow whose husband was a member of our Society, and who needs assistance, send this information to the Society at P.O. Box 95, Belleville 07109.

Although the Society is unable to provide financial assistance to a widow whose husband was not a member of the Society, the Officers act as a referral and counseling agency for those in need.

At the last annual meeting of the Trustees it was reported that this Society has a substantial case load of widows whose husbands were not members of our Society. It has also been noted that a number of referrals occur when young physicians die prematurely leaving young children, and the physician, while alive, had deferred membership in the Society. For these reasons it is once again recommended that every physician in the State avail himself of membership in this unique Society in order to obtain further protection of his own family, and to provide for other physician's families who, through adversity, may be less fortunate. It is particularly important that young physicians be encouraged to join the Society.

If a physician under the age of 50 joins the Society, the assessment is $1 for each death; members between 50 and 55 pay $2 per death. About 20 members are lost each year by death.

For more details, write to the President, Society for the Relief of Widows and Orphans of Medical Men at P.O. Box 95, Belleville 07109. The Society has been in existence since 1882.

Fees Between Doctors

On page 532 of this issue is published a guideline on professional courtesy issued by the AMA. It says, in effect, that the treating physician may, without embarrassment accept a fee proferred by a colleague; that he may accept insurance reimbursement, since the tradition applies only in doctor-to-doctor relationships and not in relationships with corporations; and that if the time required to render these services is so burdensome that the treating MD is really cutting substantially into his private-practice time, an "adjusted fee" would be appropriate. In the last category, one thinks of a psychiatrist doing psychotherapy on an hour-at-a-time, five-days-a-week basis. Here the time drained out in the care of a colleague may readily constitute ten to fifteen per cent of the therapist's total working time. Teachers in medical schools face similar problems. In any large medical school, the professor of dermatology might spend a lot of his time treating medical students.

One wonders, too, about the reimbursement for travel time and travel costs. Can a New Jersey physician expect a distinguished New York or Philadelphia surgeon to cross the river to operate on him in the latter's own local hospital? And how far down the echelon does the courtesy extend? The AMA draws the line around "dependents." Obviously a wife and minor children are thus protected. But what about a doctor's husband, about his housewifely daughter-in-law and his unemployed brother-in-law? How about clergymen, nurses, pharmacists, and detail men? With dentists a kind of *quid pro quo* can develop, since some doctors of dental surgery do expect the doctor of medicine and the physician's wife and children to pay him for dental services. This sets the pattern which the medical doctor can certainly follow without complaint. Most physicians can buy drugs at the friendly, neighborhood pharmacy at a substantial discount. Does this mean that the friendly, neighborhood pharmacist can expect a discount — like one hundred per cent, maybe?

A case might even be made out for a thesis that a doctor may neglect to get timely care for himself or family because of professional courtesy. This could come about if a physician hesitates to call out a colleague on a snowy night or for a long trip. Since the practitioner won't expect a fee, the ailing physician (or the one with the sick child) might hesitate to ask the doctor to come. Thus, it might be that physicians would themselves get better care if professional courtesy were abolished. This is not, of course, because the treating MD would give second rate care, but because the sick one would delay in sending for the therapist.

Perhaps the old tradition of fraternalism is unsuited to modern conditions of specialization, overcrowded schedules, jet travel, and jammed waiting rooms. It will not be the first of the ancient, honorable (but, alas, superannuated) traditions to go. And it will not be the last.

ORIGINAL ARTICLES

On sexual matters, we physicians are supposed to know the answers. But do we? Here is a report on a survey that seeks to find out.

Sex Education In Medical Training And Practice

William A. Layman, M.D. and Angelo Danesino, Ph.D./Jersey City*

Purpose of this study was to elicit a sampling of the attitudes and opinions of New Jersey physicians concerning the importance of sex education and knowledge in medical training and practice. In addition, we investigated questions regarding the confidence of the doctor in handling sexual matters with his patients and the physician's role and responsibility in educating the community in the area of sexual behavior. Although several aspects of these problems have been treated in recent studies[1-11] this paper represents an initial look at a broader spectrum of doctors' attitudes and opinions on these topics, with the aim of identifying areas and factors which promise to yield useful information in more detailed and comprehensive future analyses.

Subjects

A sample of 650 physicians were selected, on the basis of random number tables, from the Membership Directory of The Medical Society of New Jersey, 1964-1965. The sample was obtained by extracting ten names from each of 64 successive pages of the medical register. This gave a random sample of doctors with reference to age, training, specialty, and location.

The Measuring Device

A questionnaire, to be answered anonymously, was designed for eliciting the attitude of physicians toward the relevance of sexual knowledge both with respect to training and to his competence in dealing with sexual problems in professional practice. Each respondent was asked to assess the physician's responsibility in educating the community in the area of sexual behavior. The instrument included eight questions and space for individual comments. Two questions were particularly related to the educational process. They touched on the extent of sexual knowledge acquired during medical training, and on its relevance for professional practice. Four questions were concerned with specific problems arising from actual doctor-patient relationship, such as extent of physician's knowledge concerning sexual patterns, ability to distinguish between normal and abnormal sexual behavior, degree to which he avoids discussion and counseling in relation to sexual problems due to his lack of pertinent knowledge, and frequency of consultation on the part of patients with regard to sexual matters. A further question assessed the physician's estimate of his own sexual knowledge as compared with that of the general adult population. The final question concerned the function and role of the physician in the dissemination of scientific sex knowledge. The questionnaire form is reproduced in Table I.

Procedure

A copy of the questionnaire was sent to each selected physician with an accompanying letter in which the purpose of the project was explained. A postage-paid return envelope was included.

* From the Department of Psychiatry, New Jersey College of Medicine and Dentistry, Jersey City, New Jersey. Dr. Layman is Executive Officer of the Department and Dr. Danesino is Chairman of the Department of Psychology at St. Peter's College in Jersey City.

TABLE I—SEX KNOWLEDGE QUESTIONNAIRE

1. For physicians a knowledge of sex acquired through medical training is in general:

... Extremely important ... Somewhat important
... Important but not essential ... Unimportant

2. The knowledge of sex you received in your professional training prepared you for your practice:

... Quite sufficiently ... Fairly inadequately
... Fairly adequately ... Totally inadequately

3. How frequently have you avoided discussing sexual problems with your patients because of inadequate knowledge or training:

... Frequently ... Seldom
... Occasionally ... Never

4. In dealing with your patients concerning normal sexual patterns do you feel:

... Very competent ... Fairly competent
... Competent ... Less than competent

5. In dealing with your patients how certain do you feel in your ability to distinguish between normal and abnormal patterns of sexual behavior:

... Quite certain ... Somewhat certain
... Very certain ... Quite uncertain

6. Your knowledge of sexual matters compared with that of most adults is probably:

... Vastly superior ... About the same
... Somewhat better ... Inferior

7. How often are you consulted by your patients for advice in sexual matters:

... Frequently ... Seldom
... Occasionally ... Rarely

8. How important a function of your role as a physician do you feel dissemination of scientific knowledge concerning sexual matters is:

... Extremely important ... Somewhat important
... Important but not essential ... Unimportant

Additional comments:

Data Analysis

From 650 mailings, 250 questionnaires (38.5 per cent) were completed and returned. Table II presents the number of responses given and the mean rating for each question. In the rating procedure, a value of 4 was assigned to strongly positive agreement with the statement under consideration; 3 to positive agreement; 2 to a mildly negative or ambivalent opinion; and 1 to a strongly negative reaction to the statement. Thus, ratings ranged from 4 (strong agreement) to 1 (strong disagreement).

†Does not include the Nonresponse category.

The three highest mean ratings (Table II) were given to Statements 1 (3.72), 8 (3.51), and, 6 (3.41). More than 77 per cent of the respondents agreed that knowledge of sex acquired through medical training is extremely important. By including those who consider sex education either important but not essential (17.6 per cent) or at least somewhat important (4 per cent) a total of 99 per cent of the respondents expressed positive attitudes toward sex education in professional training. These results agree with other reports.[5,8,12,13]

Table II—Percentage of Responses (based upon 250 returns) to Each Rating Category and Mean Response Rating for Each Statement in the Questionnaire

Statement	4	3	2	1	No Response	†Mean Rating
1	77.6	17.7	4.0	0.8	0.0	3.72
2	8.0	26.4	31.6	32.8	1.2	2.11
3	8.8	19.6	29.2	39.2	3.2	1.98
4	18.0	42.4	32.4	5.2	2.0	2.75
5	34.8	23.6	32.8	6.0	2.8	2.90
6	48.4	44.4	6.4	0.4	0.4	3.41
7	29.6	42.8	17.2	9.2	1.2	2.94
8	61.6	28.0	8.0	1.6	0.8	3.51

In substantial agreement with the responses given to Statement 1, the ratings for Statement 8 include 62 per cent of responses which viewed the function and the role of the doctor as extremely important for the dissemination of scientific sex knowledge, 28 per cent who considered this function to be important though not essential, and 8 per cent who regarded the function as somewhat important (a total of 98 per cent positive responses). Analysis limited to medical specialties (43 respondents voluntarily indicated their specialities), which are particularly concerned with sexual behavior (e.g. psychiatry, obstetrics, gynecology, and urology), indicated that 93 per cent of the specialists considered sex knowledge acquired through medical training as extremely important. Those whose specialties are essentially indifferent to the area of sexual behavior (e.g. pathology, radiology, anesthesiology) expressed similar opinions (extremely important: 94 per cent). These figures are significantly higher than that obtained for the entire sample (77.6 per cent) and suggest interesting implications for further investigation. These results fall generally in line with those of other researchers.[2,5] State-

ment 6, which deals with the extent of the physician's sexual knowledge as compared with that of the normal adult received the third highest mean rating (3.41). Responses indicated that 93 per cent of the physicians felt that their knowledge was at least somewhat better than that of most adults (48 per cent vastly superior; 44 per cent somewhat better). These results are in agreement with those given to Statement 5 in which 91 per cent felt either quite certain (35 per cent), very certain (24 per cent), or somewhat certain (33 per cent) of their ability to distinguish between normal and abnormal patterns of sexual behavior. In contrast to their asserted competency in sexual matters and their ability to deal with sex problems in actual practice, two-thirds of the respondents stated that sex knowledge received during their training prepared them either fairly inadequately (32 per cent) or totally inadequately (33 per cent) for their profession. The small proportion (8 per cent) who expressed a truly positive opinion with regard to their medical training, either belong to specialties dealing particularly with sex problems (2 psychiatrists; 9 obstetricians and gynecologists; 2 urologists) or indicated that their undergraduate psychiatric training had been exceptionally superior (2 physicians).

The sharp discrepancy between asserted importance of sex education, lack of it during training, and the doctors' confidence in ability to deal with sexual matters raises important questions. These inconsistencies are emphasized by the responses given to Statement 4, which deals specifically with the capacity to assess normal behavior. This topic was purposely included in the questionnaire to assess the reliability and validity of responses given to similiar, yet slightly differently phrased statements. Although 93 per cent of the doctors stated that they were at least somewhat competent in judging normal sexual patterns of behavior, only 18 per cent asserted that they were very competent in this area. This figure is significantly lower than the ratio given for the highest ratings to related Statements 5 (35 per cent), and, 6 (48 per cent). Explanations for these differences demand more detailed analyses with a more probing questionnaire.

Statements 3 and 7 were intended to elicit some information concerning the area of doctor-patient relations with specific reference to sexual matters. In this sample, 68 per cent of the respondents indicated that they never (or seldom) avoided discussion of sex problems with their patients, while only 28 per cent were inclined to evade these questions because of their inadequate training or knowledge. As for the frequency of advice in sexual matters sought by the patients, 30 per cent of the doctors reported frequent, and 43 per cent occasional consultation. This total (72 per cent) emphasizes the extent of advice requested and, hence, the importance of knowledge and competence expected from the physician in this area.

On the basis of these results, which are supported by other studies,[1,2,9,11] it is the opinion of the investigators that a more thorough and comprehensive sex education is an indispensable requirement in today's medical training. This can be accomplished within the framework of recent suggestions for undergraduate curriculum improvement[15] and post-graduate education.[14] An increasing number of medical schools are at present tackling this problem with the introduction of special courses in sex education.[10,16,17] The need for such programs is clearly evidenced by the steadily increasing demand for advice in sexual matters by patients.[1,4,5,9,11]

A total of 98 respondents offered personal comments. Many of these were explanatory remarks relative to specific answers. Others (82 comments) brought to light relevant issues which were implicit in the questionnaire. These comments were grouped into categories in order better to define and delineate new perspectives and dimensions of the problem under consideration.

In Table III are presented groupings of factors extracted from physicians' comments. An analysis of this material raises some interesting questions. In distinct contrast to responses

TABLE III—CATEGORIES EXTRACTED FROM COMMENTS; NUMBER OF RESPONDENTS; AREAS AND FACTORS RELEVANT TO EACH CATEGORY

Categories Extracted from Comments	No. of Respondents	Areas and Factors Pertinent to Each Category
(1) Sources of sex education outside medical training.	17	1) Self-education through extensive reading particularly of psychiatric literature 2) Knowledge gained through practical and personal observation and experience. 3) Realistic sex education received by parents.
(2) Major areas in medical practice requiring scientific sex knowledge.	21	1) Marriage and family counseling. 2) Premarital evaluation and counseling. 3) Adolescence adjustment reactions. 4) Menstruation problems. 5) Birth control. 6) Psychophysiological reactions.
(3) Complexity and implications of "sex concept."	11	1) Need for emphasis on psychological (interpersonal) rather than anatomical and physiological aspects of sex. 2) Need for emphasis on emotional meaning of sexual act rather than discussion of technical, mechanical details. 3) Importance of patient's intellectual level for understanding the complexity of sex. 4) Relevance of educational, religious, cultural, and social factors with respect to sex concept.
(4) Suggestions for improvement of sex education and knowledge.	19	1) Need for parental and school guidance in sex education. 2) Need for realistic, practical, scientific approach to sex education. 3) Importance of parental example rather than attempted explanations to child's question about sex. 4) Use of *proper* scientific and anatomical terminology and nomenclature concerning sex. 5) Need for professional guidance in overcoming fears, parental misteaching, and archaic concepts concerning sex. 6) Need for symposia and lectures on sex education in public schools both for parents and students.
(5) Objections to assumed importance of medical sex education	9	1) Overevaluation of importance of sex medical training by current literature. Psychiatrists more concerned than patients. 2) Limited value of universal medical training concerning basic understanding of sex due to complexity of sex behavior. 3) Questioning of moral competence of most physicians for objective handling of sexual problems. 4) Questioning of qualification of most physicians to advise on sexual matters due to a narrow, unscientific attitude toward sex. 5) Need to stress importance of published relevant material rather than special training and personal advice. 6) Value of sex knowledge limited mostly to general practitioner area.
(6) Criticism of Questionnaire	5	1) Ambiguity and awkwardness in the wording of some statements. 2) Artificial distinction between normal and abnormal behavior. 3) Objection to conceptual narrowness of *scientific* sex knowledge. 4) Need for more detailed data.

given to Statement 8 (which overwhelmingly emphasized the primary role of the physician in the dissemination of scientific sex knowledge) the individual comments stressed mainly the contributions of the family, the school, and public agencies to the area of sex education and to the prevention of sexual pathology. A strong interest was expressed for the welfare of the community in which the physicians practice. The interactions among the several agencies and their hierarchical importance may represent a fruitful topic for further investigation.

The emphasis on the complexity and implications of the sex concept was reflected in many comments. Further, several remarks inferred that educational, economic, religious and social variables may greatly influence the attitudes and opinions of the respondents and also effect the specific personal interaction between doctor and patient. The implications of these comments for such timely problems as population explosion and birth control should receive future examination.

Some of the objections to medical sex educa-

tion emphasized the need for a better and more comprehensive didactic approach aimed at a deeper understanding of the problem in all its complexities. Close collaboration between the medical profession, family, school, and community and federal agencies was viewed as the best means for the promotion of adequate sexual education (starting at very early ages) and for the prevention of later sexual maladjustment.

Conclusions

This pilot study was based on questionnaire responses made by 250 New Jersey physicians. The purpose was to elicit data concerning (1) physicians' attitudes and opinions towards the importance of sex education and knowledge in medical training and practice; (2) the degree of confidence physicians feel in dealing with sexual problems in their professional practice; and, (3) the physician's view of his role and responsibility in educating the community in the area of sex behavior.

Most respondents considered the acquiring of scientific sex knowledge during medical training as extremely important. Approximately two-thirds of the group were fairly or totally dissatisfied with their medical sex education. However, only 28 per cent of the respondents avoided discussion of sexual problems with their patients, notwithstanding their inadequate training. Over 90 per cent viewed their knowledge of sexual matters as somewhat better or vastly superior to that of the general population, they felt at least fairly competent concerning their ability to distinguish between normal and abnormal sexual patterns. The inconsistencies between asserted importance of medical sex education, actual lack of it during training, and the physicians expressed confidence in dealing with sexual problems raise important questions for future investigation.

Consultations regarding sex were frequently (30 per cent) or at least occasionally (43 per cent) sought by patients. Concerning the physician's role in the dissemination of scientific sex knowledge, 62 per cent of the respondents considered it extremely important, while 28 per cent considered it important, although not essential. In additional comments physicians emphasized the importance of non-medical agencies (family, school, and community facilities) for the promotion of sex education, under professional supervision, and for the prevention of sexual maladjustment. The expressed need for collaboration between the medical profession and extra-medical agencies stresses the genuine interest of the physician in the welfare of his community. The data obtained in this pilot study, while generally supporting previous work, suggests several new areas and factors for research. The implication of social, educational, economic, and religious values for a scientific and comprehensive approach to medical sex education cannot be overlooked in view of such timely and urgent problems as population explosion, birth control, and legalized abortion.

Summary

Analysis of 250 responses to a specifically devised questionnaire sent to 650 randomly selected New Jersey physicians indicates that nearly all expressed positive attitudes toward sex education in medical training; that 64 per cent expressed dissatisfaction with present medical sex education; that 93 per cent feel competent in differentiating between normal and abnormal sex behavior; that 72 per cent frequently or occasionally are consulted by their patients concerning sexual matters; that 68 per cent seldom or never avoid discussion of sexual problems with patients; that 62 per cent consider the physician's role in disseminating scientific sex knowledge as extremely important and, that there is need for a joint effort between medical and non-medical agencies for efficient promotion of sex education and prevention and rehabilitation of deviant sexual behavior.

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24 Baldwin Ave.

The Sneaky Spider Can Be Venomous

Americans are having unpleasant experiences with the "Brown Recluse," a sneaky spider with a bite more toxic than that of the better know "Black Widow."† This shy brown spider* seems to be expanding its territory. Tourists contribute to its spread when they carry it home in their personal belongings.

The "Brown Recluse" hides in shoes, blankets, rolled-up newspapers, and in the dark corners of man-made structures. The result often is a bite that the person isn't aware he's getting, but which becomes painful and swollen later. A few deaths have been attributed to brown spider bites. According to the April 10 JAMA 1967) this spider's venom now is being studied for possible medical uses.

Investigators at Little Rock Veterans Administration Hospital have developed ways of "milking" the spiders of their venom by giving them mild electric shocks. The data indicate a biologic poison more potent than known snake venoms, and more toxic than venom from the "Black Widow" spider. It was only ten years ago that University of Missouri investigators discovered the poisonous qualities of the "Brown Recluse." Until then, the "Black Widow" was believed to be the only North American spider capable of inflicting serious injury on man. The female brown spider ejects twice as much venom as the male. When a brown spider bites, there may be a mild sting, but in many instances, the victim doesn't know he has been bitten. Pain may be noted in two to eight hours, followed by swelling, blistering, or even hemorrhage and ulceration. The swelling tends to spread downward. Some investigators have recommended prompt administration of large doses of corticosteroid drugs, followed by injections every other day for three more injections. Hospitalization is required for severe cases.

* Known to his friends as Loxosceles Reclusa.
† Called Latrodectus Mactans for short.

Radiation for carcinoma may lead to hydronephrosis. What accounts for this and what to do about it are suggested in this study by Dr. Fernicola.

Significance Of Hydronephrosis In Irradiated Carcinoma Of The Cervix*

Anthony R. Fernicola, M.D./Newark

Hydronephrosis in patients with carcinoma of the cervix generally signifies that metastatic disease involves the pelvic portion of the ureter. Ureteral obstruction is a grave prognostic sign[1] and has a fatality incidence varying from 65 to 80 per cent.[2] This constitutes a major problem in the management of victims of this disease and has long been recognized as the most common cause of death. However, progressive hydronephrosis with fatal uremia can often be averted by instituting one of several surgical measures including urinary diversion.

Ureteral obstruction has a significant relationship to cervical cancer that has been treated by irradiation. Although ureteral obstruction ordinarily indicates tumor extension in pre-treated patients, the development of hydronephrosis in patients previously treated by irradiation must be considered as a sign of either invasive tumor or of a sequela of irradiation.[3] Fatal hydronephrosis has been observed without demonstrable cancer in numerous patients who have had radiotherapy.[4] Conversely, hydronephrosis shown on pretreatment pyelograms has been seen to improve following radiotherapy.

During the course of management of patients given irradiation there became evident, on intravenous urography, the presence of hydronephrosis in six patients in our series. Three of those are here illustrated. A decision was made to observe these patients to determine whether metastatic disease or renal impairment would predominate.

The purpose of this paper is to demonstrate by X-ray evidence, the behavior of hydronephrosis which develops in patients who had received radiotherapy for carcinoma of the cervix. The enlightening observations reveal the necessity of adopting a new concept of, and an investigative attitude toward this complication. Most important is the discriminating posture that must be assumed before major urologic measures are undertaken to rectify this condition.

Case One

A 53 year old woman came to the Black-Stevenson Clinic, Presbyterian Hospital, Newark, with a history of vaginal bleeding. This had started two years before. There was a record of radium application followed by X-ray therapy. Dosage of radiotherapy was not specified. The pathologic diagnosis was adenocarcinoma of the cervix, classified Stage I. Examination one year after the last X-ray therapy disclosed a small uterus with normal adnexae. The cervix was atrophic and scarred. A year later, she reappeared at the Clinic with a dysuria and hematuria. Urinalysis showed four to eight white blood cells and red blood cells. Four months later, the intravenous urogram was normal (Fig. 1, A). But two weeks later, cystoscopy revealed

* Read before the Joint Sections on Obstetrics and Gynecology and Urology, Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 15, 1967. This work is from the St. James Hospital in Newark.

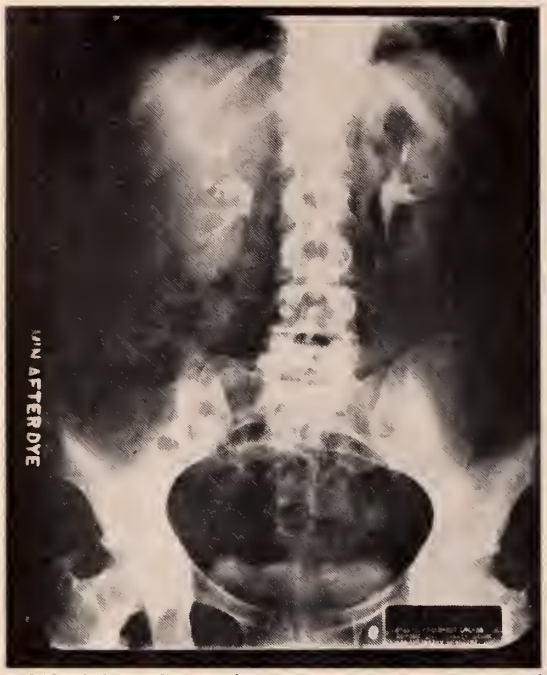


FIGURE 1A Normal intravenous urogram on March 6, 1959.

an area of ulceration surrounded by a zone of hyperemia and edema on the posterior bladder wall. Biopsy of the lesion disclosed ulcerative urocystitis.

A few months later (three years following radium application), the intravenous urogram revealed marked hydronephrosis on the right and normal left urogram (Fig. 1, B). At that time, cystoscopy disclosed no obstruction to the passage of a number six French ureteral catheter to the right kidney pelvis. Hydronephrotic drip of clear urine appeared from the ureteral catheter. The bladder urine was normal on examination. The blood urea nitrogen was nine milligrams per cent. Nine weeks subsequent to urographic evidence of hydronephrosis, the intravenous urogram was normal (Fig. 1, C). Intravenous urograms obtained on April 27 (Fig. 1, D) and May 23, 1960 were normal.



FIGURE 1B Approximately three years after conclusion of radiotherapy the intravenous urogram reveals marked right hydronephrosis.



FIGURE 1C Nine weeks later on January 9, 1960 the intravenous urogram reveals no abnormality.



FIGURE 1D Intravenous urogram on April 27, 1960 is normal.

Case Two

A 72 year old woman was referred to the Clinic with a history of vaginal bleeding the previous year. Examination showed a firm and hard cervix. The uterus and adnexae were normal. The urinalysis was essentially negative. The blood urea nitrogen was ten milligrams per cent. The diagnosis was squamous cell carcinoma classified Stage II. Starting three months later, she received cobalt 60 radiation for a total tumor dose of 5000 roentgens given in 25 treatments. She received external radition with the 250 kilovolt machine for a total tumor dose of 4000 roentgens given in 30 treatments. No pre-treatment urogram was available.



FIGURE 2A Approximately six months after completion of cobalt radiation the intravenous urogram shows marked left hydronephrosis.



FIGURE 2B Two weeks later the I.V.P. demonstrated persistent left hydronephrosis.



FIGURE 2C One week later a No. 6 French ureteral catheter discloses no obstruction within the left ureter.



FIGURE 2D Approximately thirteen weeks following initial evidence of hydronephrosis the intravenous urogram reveals a disappearance of hydronephrosis.

Some months later, she complained of lower abdominal discomfort. Approximately six months following cobalt radiation the intravenous urogram showed marked left hydronephrosis and normal right upper urinary tract (Fig. 2, A). The following week, the intravenous urogram showed left hydronephrosis and right hydroureter (Fig. 2, B). The blood urea nitrogen was twelve milligrams per cent. Urinalysis revealed 10 to 12 white blood cells and fifteen to twenty red blood cells. Cystoscopy disclosed no obstruction to the passage of a number six French ureteral catheter to the left kidney pelvis (Fig. 2, C). Thirteen weeks following urographic evidence of hydronephrosis the intravenous urogram showed a normal upper urinary tract bilateral (Fig. 2, D). At that time, the intravenous urogram was normal. Five months later, she was dead of a metastatic carcinoma.

Case Three

A 42 year old female appeared at the Clinic with a history of supracervical hysterectomy for uterine fibroid 8 years earlier. Her chief complaint now was vaginal spotting of blood. Examination revealed a large, firm, irregular cervix. There was no parametrial thickening. The pathologic diagnosis was adenocarcinoma classified Stage I. Cobalt 60 radiation was given for a total tumor dose of 6200 roentgens. Roentgentherapy through vaginal cones with the 250 kilovolt machine was also administered. For a total tumor dose of 4000 roentgens. No pre-treatment urogram is recorded.

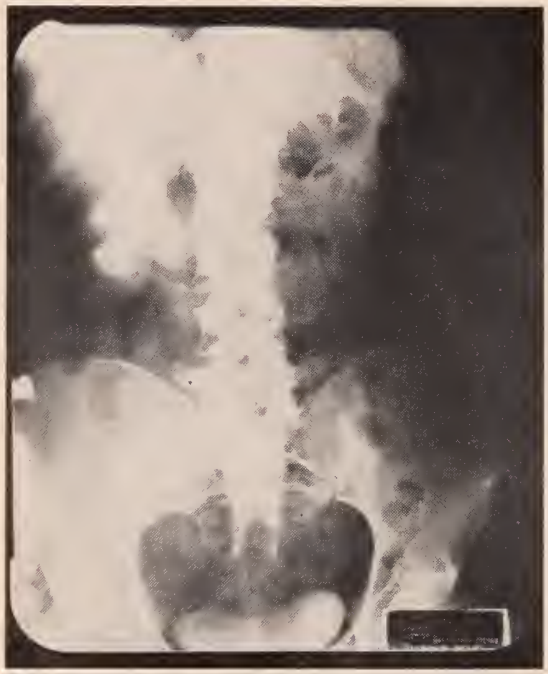


FIGURE 3A One and one-half years after completion of cobalt therapy the intravenous urogram reveals right hydronephrosis.

Ten years after the hysterectomy, she complained of dysuria. Urinalysis revealed eight to ten red blood cells. Approximately one and one-half years following completion of cobalt therapy the intravenous urogram showed right hydronephrosis and hydroureter and normal left upper urinary tract (Fig. 3, A). A few weeks later, cystoscopy disclosed no obstruction to the passage of a number six French ureteral catheter within the right ureter. Biopsy of an ulcerative lesion on



FIGURE 3B Three months later the intravenous urogram reveals bilateral hydronephrosis and hydroureter.

the trigone was reported urocystitis. The intravenous urogram showed bilateral hydronephrosis (Fig. 3, B). Approximately four and one-half months following urographic evidence of hydronephrosis the intravenous urogram demonstrated partial regression of hydronephrosis (Fig. 3, C). The following year, the intravenous urogram was normal (Fig. 3, D). The intra-



FIGURE 3C Approximately six weeks later the I.V.P. shows artial regression of bilateral hydronephrosis and hydroureter.

venous urograms that year and the next year were normal.



FIGURE 3D Approximately eight and one-half months after initial evidence of hydronephrosis the intravenous urogram demonstrates normal upper urinary tract bilateral.

The known causes of ureteral obstruction in carcinoma of the cervix are recognized as carcinomatous infiltration of the ureter and periureteral metastases, ureteral and periureteral fibrosis as sequela of parametritis and tumor necrosis, and postradiation stricture. These conditions present an irreversible and progressive obstructive ureterecstasis and pyelecstasis. The resultant hydronephrosis is correctable by one of several surgical modalities. Ureteroneocystostomy is the one most commonly used.

A distinction must be made, however, when hydronephrosis develops in patients who have been irradiated for carcinoma of the cervix. The obstructive, irreversible ureterecstasis and pyelecstasis are forms of hydronephrosis which must be differentiated from non-obstructive, reversible ureterecstasis and pyelecstasis which is "hydronephrosis" produced by an apparently reversible radiation ureteropathy. This form of "hydronephrosis" starts about one-half year to three years following completion of radium or cobalt therapy. These patients are virtually asymptomatic. Microscopic hematuria or a transient episode of dysuria or abdominal discomfort occur and signify the necessity for urologic investigation. Total kidney function determined by blood chemistry and intravenous urography is within normal limits. Cystoscopy discloses no ureteral obstruction to the passage of a number six French ureteral catheter on the side of the hydronephrosis. Cervical carcinoma in these patients is classified Stage I and Stage II.

Regression and disappearance of "hydronephrosis" are seen in two months to four months following initial urographic evidence of dilatation of the upper urinary tract. An intravenous urogram is obtained at two month intervals in order to ascertain the expected regression of ureterecstasis and pyelecstasis.

Only hypothetical explanations can be offered for the spontaneous disappearance of hydronephrosis in patients irradiated for carcinoma of the cervix. Presumably there occurs a radiation effect on neurogenic, myogenic, or vascular elements within the lower ureteral segment to produce a *temporary* neuromuscular dysfunction or inactive peristalsis (the inert ureteral segment). Also, a radiation-induced parametritis which resolves spontaneously may be a factor.

Conclusions

1. Hydronephrosis which develops following radiotherapy for carcinoma of the cervix may disappear spontaneously.

2. This condition is apparently the result of a reversible radiation ureteropathy heretofore not recognized as a clinical entity.

3. These observations indicate that a decision to buy time can spare countless women the necessity of undergoing corrective major surgery for hydronephrosis.

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402 Mt. Prospect Avenue

Here, in a few pages, is a GP's guide to medical ophthalmology.

Eye Pathology Of General Medical Interest*

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The eye is often an indicator of what is going on elsewhere in the body and it is also subject to many of the diseases that affect other organs. Consider, for example, the eye in *diabetes.* The ophthalmologist may be the first to suspect the disease during a "routine" eye examination. I have seen several cases of "acute myopia" in adults who previously had no visual difficulty for distant vision and who did not know they were diabetics. I remember a 47 year old woman who said that until one week ago she could see well for distance but needed reading glasses. Now she could not see well in the distance and had to be driven to the office, but she did not need her reading glasses anymore. There had obviously been a change in the density of the media which we find when the blood sugar goes up suddenly. She was referred to an internist who found a high blood sugar which was controlled by diet and insulin.

The eye changes we associate with diabetes are seen usually in long standing cases, frequently in patients who have received good treatment and are well controlled. The changes include rubeosis iridis or the presence of new formed vessels on the anterior surface of the iris. When these fibrovascular membranes contract they cause the pigmented border of the pupil to curl outward — ectropion uvea. They may also grow into the angle of the anterior chamber and block the corneoscleral trabecular spaces leading into the Canal of Schlemm, or the outflow channel for the aqueous humor of the eye, and cause a secondary glaucoma of the hemorrhagic type. This iris is likely to bleed during cataract extraction and may even bleed spontaneously to produce hyphema. These eyes are usually lost since no adequate operation has been devised to control the glaucoma. Another change in the iris is vacuolization of the pigment epithelium with the tendency of the pigment to be released and float free during manipulation, as in a cataract extraction.

The changes of greatest general interest (since the non-specialist frequently notes it in his ophthalmoscopic examination) are those involving the retina. Diabetic retinopathy is well known by all doctors. It consists of microaneurysms in the inner nuclear and plexiform layers and the presence of hard waxy exudates in the outer plexiform layer, usually about the macula. In histologic sections these are dramatically seen and help explain the disturbance to vision and the sequelae such as vitreous hemorrhages and retinitis proliferans. The latter occurs when new formed vessels in a connective tissue stroma are formed, usually about the optic disk. These formations may become attached to the retina some distance away, and when the vitreous shrinks can result in retinal detachment. The characteristic changes, which are bilateral, are found in the area between the upper and lower temporal vessels of the retina and about the optic nerve. The optic disk itself is normal in appearance. The exudates have the appearance of hardness, are sharply demarcated and are white or yellowish-white. They are discrete or confluent and frequently form circinate figures. The retinal vessels are usually normal

* Read by invitation before the Illinois State Medical Society on May 24, 1967

in appearance, although in elderly persons the signs of aging of the vessels and hypertensive and arteriosclerotic changes may be found in addition to the hemorrhages and exudates characteristic of diabetic retinopathy. The exudates consist of colloid or hyaline material, lipoprotein in nature. It is not necessarily the person with severe diabetes who suffers from the retinal changes, but more often the person with mild diabetes who has had hyperglycemia for a long time. It is of interest, too, to note the relation of diabetic retinopathy with Kimmelstein Wilson's Disease.

Of general medical interest are the changes that take place in *hypertensive retinopathy*. It is of great value in understanding the fundoscopic findings to translate these into the picture seen in histologic section. According to the Keith-Wagener Classification, we speak of hypertensive retinopathy as Group I to Group IV. Group I shows an essentially normal fundus but with minimal attenuation of the retinal arterioles. On histologic section the retinal artery shows incipient minimal thickening of the wall. There is little or no compression of the underlying vein. In Group II the retinal vessels show some narrowing and exaggeration of the light reflex. Compression of the vein at the vascular crossings is present. On section, the thickening of the arterial wall is increased and the underlying vein is compressed. In Group III the vessels show changes similar to those seen in Group II, with the addition of cottonwool patches, edema of the retina, and retinal hemorrhages. The histologic section shows retinal edema in the plexiform layers, cottonwool spots and hemorrhages in the nerve fiber layer, in addition to the changes seen in Group II. The fundus picture of Group IV is similar to that of Group III with the addition of a measureable edema of the optic disk. If the edema involves Henle's nerve fiber layer we have a "macula star."

Another severe vascular disorder of the eye is central retinal vein thrombosis. Here the ophthalmoscopic picture is often called "Dante's Inferno." There is sudden loss of vision which, however, does not occur as abruptly as in closure of the central retinal artery. Depending on the degree of circulatory disturbance, vision is reduced to finger counting or hand movement perception. Vision may improve after a time, or it is completely lost later when complications (such as secondary glaucoma) set in. When the obstruction is incomplete or involves the superior temporal branch a considerable amount of vision may remain.

In the typical severe case, the ophthalmoscopic picture is dominated by the results of local circulatory disturbances, by hemorrhages, and by edema. The optic disk is red and slightly swollen and the margins are blurred. The veins of the optic disk and the retina are swollen and tortuous and may be several times their normal calibar, and the blood column is dark red. The arteries are narrow and difficult to recognize. All over the fundus are numerous hemorrhages of all shapes and sizes extending far into the periphery. The hemorrhages in the superficial nerve layer are flame shaped and radial, those in the deeper layers are round and irregular. Later, here and there between the hemorrhages, are found white exudates and retinal edema.

In the retina itself the changes following obstruction of the central vein consist mostly of edema and hemorrhages and their consequences. The hemorrhages are mainly in the inner layers and the edema varies in degree and is especially prominent in the internuclear layer leading to large cystic spaces. The edema extends to the nerve head which is swollen with blurred margins. When the blood begins to be absorbed the deficient oxygen supply is responsible for the appearance of hyaline and lipoid deposits. The inner layers of the retina atrophy, with hypertrophy of the supporting glial and connective tissue replacing the lost elements. The rods and cones and their outer nuclear layer are not affected. There is development of a collateral circulation frequently forming tortuous glomerular networks.

A most important complication of central retinal vein obstruction is secondary glaucoma

of the hemorrhagic type. This occurs in perhaps 20 per cent of the cases and usually in about three months after the acute attack. The clinical picture is characterized by extreme pain, by the hemorrhagic nature of the glaucoma, and by its intractability. The iris shows new formed blood vessels on its surface with the membrane extending into the angle of the anterior chamber with bridge synechia and broad adhesions. The shrinkage of the membrane causes a curling forward of the pigment layer — ectropion uvea. This may be an attempt to form a collateral circulation in order to find new means for carrying away the venous blood after obstruction of the central vein. This rubeosis is also found, as noted, in certain cases of diabetes with similar affects. The glaucoma usually resists all treatments by miotics and by surgical means and the pain eventually leads to enucleation of the globe.

Syndromes bring together a mass of apparently disconnected anomalies, rather than disturbances of one organ or one system, or on the basis of a metabolic disorder. The embryologic approach of attempting to explain syndromes in terms of disturbances in ectodermal or mesodermal tissues has some value as does, to a lesser extent, the result of anomalous effects of particular genes. Predominantly nerve ectodermal syndromes are seen in the phakomatoses. Genetically determined minimal blemishes of the skin and possibly also from the central nervous system are present at birth and in early infancy in the whole group. The generic name of phakomatoses means "Mother Spot" and four clinically distinct types are recognized. Each has a skin manifestation and often ocular disturbances and pathologic brain manifestations. These are known as Von Recklinghausen's Disease, Bourneville's Disease, Sturge-Weber Syndrome, and Von Hippel Lindau Syndrome.

A familiar syndrome is that of Laurence-Moon-Biedl. This is characterized by obesity, hypogenitalism, mental deficiency, polydactyly, and retinitis pigmentosa. The ocular changes are almost constant while some of the other components may be lacking. Congenital deaf-mutism may be present and may possibly appear as a varient to the retinal dystrophy.

The fundus changes are quite characteristic. The ophthalmoscopic picture is characterized by pallor of the optic disk, narrowing of the retinal arteries and veins, pigment deposits in the retina about the attenuated vessels giving the appearance of bone spicules. The disease is a primary degeneration of the neuroepithelium of the retina on a hereditary basis and involves both eyes. The visual disturbances are characterized by night blindness and by a gradually increasing concentric limitation of the visual fields (ring scotoma) leading to tubular vision and eventually to marked diminution of central vision.

Histologic cross section of the retina shows the pathogenesis. The rod and cone layer in the periphery are absent and the narrowed vessels are ensheathed in pigment. The pigment epithelium is intact and the choroid is normal. The differential diagnosis is made from diffuse chorioretinitis which gives the ophthalmoscopic picture of a pepper and salt fundus and in which, on cross section, the pathology is seen to involve the choroid and retina and especially the pigment epithelium. This shows areas of loss of pigment and bunching up of pigment. The bare areas allow the sclera to be seen and represent the salt part; the accumulations of pigment are the pepper. This illustrates again how visualization of the histologic cross section helps us in recognizing and understanding pathologic processes in the structures of the eye.

1111 Park Avenue

Why can't we just give a new drug and see if our patients get any better? Here's why: there is a lot more to appraising drugs than that, especially when the hope is to modify human behavior.

Evaluation Of New Drugs For Schizophrenia*

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The past ten years have been a decade of psychopharmacology which has revolutionized the treatment of schizophrenia. Psychiatrists and other physicians have been provided with a succession of drugs which allow control of the group of symptoms which form the schizophrenic syndrome. By the use of these drugs many schizophrenic illnesses are shortened, so that the patients can return quickly to the community, and the serious consequence of institutionalization is prevented. By continued treatment with drugs, relapses may often be prevented. Even in the sizable group of chronic patients, the severity of the illness may be mitigated so that patients previously tormented by their symptoms may now lead more comfortable if unproductive lives.

However, a closer look at the dozen useful antipsychotic compounds available in the United States leads to a feeling of disappointment. None of them promises more than a damping-down of the schizophrenic's hyperactivation, and thus a temporary modification of his behavior allowing for learning new adaptations to the environment. This is probably all we can hope for until knowledge of the etiology of the several syndromes of schizophrenia suggests more specific forms of therapy. Indeed, many other branches of medicine function adequately with only symptomatic control. Even limited and non-specific treatment of schizophrenia has been of tremendous value in reducing morbidity and mortality. What is more disappointing is the very limited range of drugs available. About eight of the dozen are phenothiazines. Notwithstanding the advertising of the industry (which has been more guarded recently), these differ only as regards milligram potency and side effects. To show differences in therapeutic efficacy when adequate doses are given requires unreasonably large numbers of patients, and in the individual case, the physician is usually guided by the side effects and his patient's reaction to them. Of drugs which are not phenothiazines, one thioxanthene drug has been available for several years, and it is probable that other thioxanthenes (now under investigation) will in time become available. Whether they will offer any advantages over the phenothiazines remains to be seen. One butyrophenone is now available; this seems better than the phenothiazines for mania, but roughly comparable for schizophrenia. Reserpine and its derivatives probably have very little place in the treatment of schizophrenia today. On the horizon are a few compounds with more or less unusual structures, dibenzoxepine or indole derivatives, which appear to have definite antipsychotic activity. Probably the prime reason for the limited spectrum of antipsychotic compounds available is the limited range of possibilities for discovering such compounds. Without an etiology for schizophrenia (which might predict the structure of compounds with specific anti-schizophrenic activity) the preclinical pharmacologist must search for drugs which

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show, in animals, activity resembling that of the phenothiazines. Otherwise the discovery of new compounds is accidental. The finding of the efficacy of chlorpromazine in schizophrenia was quite as serendipitous as the discovery of penicillin. Similarly the efficacy of haloperidol was discovered by Janssen of Belgium when he was looking for a Demerol®-like compound without addicting properties. One may of course look for anti-schizophrenic properties and accidentally find antidepressive activity, as happened with imipramine.

In searching for new antipsychotic drugs, we find the laboratories of pharmaceutical companies proceeding slowly and laboriously through a series of many compounds more or less related to items already available. These are synthesized and tested in animals of several species. In looking for phenothiazine-like activity, the animal pharmacologist is primarily interested in behavior tests; for instance, in locomotor suppression, avoidance-escape suppression, taming, increased behavioral arousal threshold, decreased wakefulness, production of catalepsy, suppression of audiogenic seizures, antagonism to the effects of amphetamine, and hallucinogens. All these tests may be quantitated so that the new drug may be compared with standard drugs. If the tests suggest that the compound is worth developing for clinical testing many other kinds of information must be obtained from animals. Effects on the autonomic, endocrine, cardiovascular, gastrointestinal and renal systems must be measured. Potentiation and antagonism must be studied. Convulsion threshold, tissue irritation, acute and chronic toxicity, tolerance, cumulation, and drug dependence must be studied. Routes of administration, therapeutic ratio, and protection against overdosage must be determined.

The prediction of drug effects from animal to man still leaves much to be desired. The types of information which should be predicted include: (1) the nature and magnitude of the "therapeutic" drug actions; (2) the types of patient likely to be benefited; (3) the therapeutic dose range; (4) the time-course of drug action; (5) the steepness of the dose-response correlation; (6) the nature of likely side effects and the doses at which they are likely to occur; (7) the possibility of tolerance or cumulative effects during long-continued administration; (8) possible emotional or physiologic dependence.[1]

If the drug appears promising and if the animal pharmacologists have obtained enough information to make approximate predictions in these areas, the first human trials may be planned. Phase 1 of the clinical pharmacological trials (according to the New Drug Regulations) starts when the new drug is first introduced in man, only animal and *in vitro* data being available, "with the purpose of determining human toxicity, metabolism, absorption, elimination and other pharmacologic action, preferred route of administration, and safe dosage range." Phase 1 studies are often carried out in normal volunteers; prisoners are frequently participants in these trials. The procedure is made as safe as possible, with constant observation, and starting from very small doses. Only a limited amount of information may be obtained from such studies in "normals" and this is mainly on side effects; for instance, whether the drug causes nausea or hypotension, drowsiness or excitement, but not whether it is likely to be useful in schizophrenia, or whether prolonged use is likely to be associated with jaundice or agranulocytosis. One pharmacologist has expressed the opinion that studies on normal subjects should be all that is needed to predict drug effects on patients, at least as far as phenothiazine-like compounds are concerned, if the behavioral modifications desired in patients can be sufficiently specified. Certainly, if we expect to predict efficacy in patients from behavioral modifications in animals, it should be all the more likely that similar modifications in normal humans should provide useful predictions.

Phase 1 studies usually continue in patients and are followed by Phase 2 studies, which (according to the Regulations) cover the initial trials on a limited number of patients for specific disease control or prophylaxis purposes. The line between Phase 1 and Phase 2

is not as clear as would appear from their definitions. The early trials in patients must provide information on pharmacologic actions and dose range which cannot be obtained from normal volunteers. After all the animal work and trials in "normals," it is usual for predictions on effective or safe dosage range to be grossly wrong, especially when the drug is structurally unusual.

The investigator designing very early trials on patients plans on collecting clinical data on therapeutic efficacy and side effects, physiologic data on autonomic and other actions such as changes in sleep, appetite and weight, laboratory data on liver and blood changes, EEG and EKG changes, and other more specialized areas which vary from investigator to investigator. To measure antipsychotic effects on behavior one must have a drug, a group of patients, a treating physician, observers of behavioral changes and a setting or milieu in which the treatment occurs. As Cole[2] has put it, the question to be answered is "Does Drug A in patients of Type B at Dosage C as administered by Therapist D in Setting E produce changes in Measure F as noted by observer G?"

With regard to the selection of Drug A, the investigator has an ethical duty not only to test drugs which are unlikely to harm the patients, but also to test only drugs which have some chance of helping them. There is little justification for testing in schizophrenics drugs which have only stimulant or antidepressant properties. The investigator selects either compounds which on the basis of animal and early human testing may be expected to show antipsychotic activity, or drugs which because of hypotheses derived from an etiological theory of schizophrenia might be expected to benefit specifically the schizophrenic even though they show no promising effects in non-schizophrenics; these might include compounds related to adrenochrome, serotonin or indole.

The patients most likely to be found in an early clinical drug evaluation unit carrying out very early studies are chronic schizophrenics, carefully selected from a much larger group of patients on the basis of specific criteria of sex, age range, lack of organic disease or brain damage, and lack of response to standard treatments. Such a homogeneous group usually shows a stability of psychosis within narrow limits and a lack of response to placebo. They should show undoubted schizophrenic symptoms yet not be so disturbed that they must be constantly maintained on antipsychotic drugs. One of the most important stages in early drug trials is the preliminary period without medication, the baseline or observation period, when the patient receives care and attention but no medication other than at most a placebo identical in appearance and taste to the study medication. The length of this period varies; such extraneous factors as availability of ward staff in the hospital, and their tolerance of disturbance, may decide whether the baseline period is three weeks or three months. If the baseline period is short the period of drug administration should be long, so as to permit the investigational new drug to replace completely any persisting previous medication.

Initially, the dosage level, C, is generally small. The speed of increase is dependent upon the effects found at each preceding dose level. If a steady state is reached during the baseline period it is possible to obtain reasonable dose response curves, and to find a maintenance dose within two months, so that a third and final month of treatment may require only small adjustments of dosage. It is essential to obtain accurate information on effective dose range before carrying out double-blind comparative studies against standard drugs, so that the choice of inappropriate comparative doses does not introduce bias.

The therapist, D, is the investigator who designs the study, prescribes the medication, and carries the responsibility for errors. It is his duty to obtain all possible information about the drug before and during the study. He organizes the team of observers and keeps a close clinical eye on the study. It is preferable for him to leave objective assessments

of the patients to the observing team; this is essential of course if they are "blind" to drug and dosage and he is not. He also is responsible for reporting the study to the sponsor, usually a pharmaceutical company, his granting organization (often U.S. Public Health Service), the research committee of his hospital, and his colleagues, through the scientific journals.

E, the setting, comprises milieu factors such as the type ward—closed or open—its size, the number of patients, their recreational, occupational and other facilities, what other therapies are being administered, and so on. Unwanted behavioral changes may be produced by quite small changes of the interpersonal milieu; moving one disturbed patient to another ward, or calming him with tranquilizers, may cause large effects on the behavior of other patients. Schizophrenics are peculiarly sensitive to interpersonal relationships; the number of possible two-person interactions on a ward is far greater than the number of patients there. Adding one patient to a ward of 60 permits 60 new two-person interactions, and there are already nearly 1800 possible there. Similarly, taking one patient away, or modifying his social behavior, can remove or alter a large number of interactions.

The measures, F, include standard behavioral rating scales completed by psychiatrists and nurses at baseline and at intervals during the study, global clinical assessments of degree of psychosis and of change, preferably on scales with definitions for each level, side effect check lists completed as frequently as every day, measures of blood-pressure, pulse, temperature, sleep duration, appetite, weight; liver function tests, blood counts, urinalyses, electrocardiograms, electroencephalograms; even measures of skin sensitivity to light are used by some investigators. All these should be integrated into a coherent picture representing the overall effects of the drug. Among the most useful behavioral rating scales are the Inpatient Multidimensional Psychiatric Scale[3] and the Brief Psychiatric Rating Scale[4] for the psychiatric observers, and the Nurses Observation Scale for Inpatient Evaluation[5] and the Psychotic Reaction Profile[6] for the nursing observers. Even in a study on a small number of patients, finding similar changes in independent ratings by psychiatrists and nurses is good evidence for the validity of the measures. The scales quantify, but do not substitute for, clinical judgment; there are no objective measures of behavior which do not involve the observer's clinical experience and intuition.

G is the team of observers, including psychiatrists, nurses, attendants, and sometimes a psychologist. They should be trained in observational technics, and in recording their observations. Their skills should supplement and complement each other; nurses are not expected to have the skills of psychiatrists and vice-versa. Investigators should always look for good observers in every discipline; they are rare but form the greatest strength of any drug study. Large studies are made invalid by the use of a variety of observers of different levels of skill and training, while small studies may be of great value when observations are carried out by a well-trained and skillful team.

Attention to factors A to G, together with appropriate design and analysis, should make possible a meaningful report. The analysis and report may take as long as the study unless prepared for well in advance, so that all needed data are easily located. There is little call for complex statistical design and analysis in early drug studies. Cross-over or Latin square designs should be avoided. Non-parametric or short-cut statistics may be more appropriate than apparently more powerful technics. Essentially the design of any study should maximize the chance of making and recording valid observations and minimize bias, while avoiding hazards for the patient.

By the use of these methods, together with his own experience and judgment, the investigator should be able to state whether the compound appears to have potential use in schizophrenia and whether the side effects are dangerous, moderate or mild. He cannot

at this time state its relative potency compared with standard drugs, except on a rough milligram for milligram basis. It appears almost impossible to say whether one potent antipsychotic drug is "better" or "worse" than another, even when large double-blind controlled studies are done. Drugs differ in strength, which affects the dosage used, and in side effect pattern; some are more sedative, others cause more extrapyramidal symptoms or autonomic effects. It can be said of many antipsychotic drugs that "No other drug has been shown to be more effective than Drug X." This is only partly attributable to methodologic problems; until there are specific therapies for schizophrenia soundly based on etiology, available treatments will have a narrow range of activity.

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The Needle In The Knee

A housewife drops a sewing needle on the carpet and kneels to look for it. A flash of pain in one knee. She leaps to her feet and yanks the tiny steel shaft from her flesh and applies an antiseptic to the wound. In the searing moment of pain she does not notice that part of the needle is missing, broken off in the knee joint. days later she will visit her physician with a knee that is throbbing and swollen.

The needle-in-the-knee pattern of injury is almost uniform and thus easily recognizable. After hearing the victim's story of injury and subsequent pain and swelling, the physician should suspect that needle fragments are still in the knee.

Ramsey and Goodman recommend that immediate measures be taken to locate the fragment by X-ray and remove it from the joint. Small metallic foreign bodies may be tolerated in the body for an indefinite period without causing symptoms and do not necessarily require removal. But, needle fragments located in articular cartilage, subchondral bone, synovium, adjacent soft tissues, or diarthrodal joints will cause symptoms until surgically removed. The potential of serious infection introduced by the needle is another factor favoring early surgical removal. The authors reported 21 "needle in the knee" cases. All the victims were children playing on the floor or women kneeling to search for the lost needle.

Although either end of the needle may penetrate the knee, the authors found it more common for the point of the needle to be in the carpet and the eye end to penetrate the joint. In each case the pain of the puncture caused the victim to cry out and leap to a standing position. The needle, imbedded in bone, cartilage, or other tough tissue, was snapped into two or more pieces by the sudden shearing motion.

Because the fragments may be difficult to locate the X-ray search should be meticulous. In 5 of the 21 cases studied, two operations were necessary to find and remove all fragments.

Ramsey, R. H. and Goodman, F. G.: *Journal of the American Medical Association, January 2, 1967.*

If you don't bind your JOURNALS, better cut this item out and save it. It will be worth saving.

What The Social Security Disability Program Means To You And Your Patients

Jarvis M. Smith, M.D./Trenton*

In 1965, social security coverage was extended to physicians in private practice. Its disability protection can be a valuable supplement to your present disability coverage. In the social security disability program, a person under 65 who is too disabled to work may receive up to $152 in monthly benefits. If he has dependents, family benefits can go as high as $339 a month.

Benefits can now be paid to a person whose disability has lasted (or is expected to last) for 12 months or longer, or to result in death. Formerly, a person was eligible only if his impairment was expected to continue for a long and indefinite time, or to result in death. This liberalized provision benefits a large number of persons disabled by non-permanent impairments resulting from accident or illness.

Already, in New Jersey, some 32,790 disabled persons and 18,480 dependents are receiving about 4 million dollars a month in social security disability benefits. Nationwide, over a million disabled persons — plus about a million dependents — are getting payments of about $1.75 billion a year from the program. You may have patients who are missing out on benefits because they are unaware of the provisions of the law. You can perform a valuable service for them in this regard. If there is any possibility of their being eligible for these benefits, refer them to a social security office for further information. You can help speed the decision on your patient's claim by promptly responding to his request that you report the medical data from your records needed to evaluate his disability.

Here, to give you a better understanding of how the program relates to your practice, are answers to the questions physicians most frequently ask about the social security disability program.

Where do I send a patient to inquire about disability benefits?

Refer him to his social security office. If he cannot get there because he is in a hospital or is unable to leave home, the office will send a representative to visit him.

What do you mean by "disabled?"

A "disabled" person is one who has a physical or mental impairment that prevents him from doing not only his usual work, but any substantial work in keeping with his age, education, and experience. (Several provisions apply to a totally blind person: for instance, even if he is able to work, he can have his social security earnings' record "frozen" to protect his future benefit rights; also, if he is 55 or over, he may qualify under a special definition of disability. For further information, inquire at a social security office.)

* Dr. Smith is medical director of the State Rehabilitation Commission.

Is the impairment the only factor in determining disability?

Not always. Although a person is considered disabled only if his impairment is the primary reason he can't work, consideration may also be given to such factors as his age, education, training, and work experience.

In most cases, a person who is found disabled has an impairment so severe that his condition alone shows he cannot work. But it is possible for a person to be considered disabled because of a combination of medical and vocational considerations. This occurs when the medical condition prevents him from doing his usual work and — considering his age, education, and previous work experience — he cannot be expected to do any other type of work.

Are benefits paid only in cases of permanent disability?

No. Benefits are paid if the disability has lasted or is expected to last at least 12 months or to result in death. This covers non-permanent impairments resulting from accident or illness as well as chronic conditions.

How soon can benefits start?

Benefits begin after a waiting period of 6 full calendar months following the onset of disability. Therefore, the first payment is for the 7th month after the month in which a person became disabled.

What about a person who did not apply for benefits while he was still disabled? Can he receive any back payments now that he is recovered?

Yes. Even a person who has returned to work may be eligible for some benefits if severe disability prevented him from working for at least 12 months. However, the longer the delay between his recovery and his application for benefits, the fewer months of back payments he can receive. If more than 14 months elapse after he recovers and before he applies, no benefits are payable.

A cardiac patient who gets angina on slight exertion tells me you turned down his claim. How come?

Probably for a non-disability reason, such as his not having worked long enough in jobs covered by social security to meet the disability earnings requirement. To acquire disability protection, a worker must generally have social security work credits for at least 5 of the 10 years preceding the onset of his disability. Persons disabled by blindness before age 31 may need less than 5 years. Inquire at a social security office for further information.

What are the most common impairments among workers who are found disabled?

The most frequent causes of disability have been: arteriosclerotic heart disease (including coronary disease), emphysema, schizophrenic disorders, hypertensive heart disease, pulmonary tuberculosis, osteo-arthritis and rheumatoid arthritis. These conditions may help you identify patients likely to be qualified for benefits. But don't feel that they limit you in any way. Send any patient you think might qualify to his nearest social security office.

How about someone who has never been able to work — someone disabled since birth, for instance?

Under the "childhood disability" provisions, a person continuously disabled since before age 18 can receive disability benefits starting at age 18 or later. He need not have a work record of his own. Benefits can be based on the earnings' record of either parent. Payments begin when a parent covered under social security dies or becomes entitled to disability or retirement benefits. Benefits can continue as long as the son or daughter remains disabled.

The most common causes of disability in this program are mental retardation, epilepsy, cerebral palsy, congenital defects, late effects of acute poliomyelitis, congenital syphilis, and acute encephalitis.

Who determines whether or not a person is disabled?

Disability decisions are made by an evaluation team consisting of a physician and a counselor skilled in vocational evaluation. The team works in an agency of the state in which the applicant lives — in New Jersey, at the New Jersey Rehabilitation Commission, Disability Determinations Service, 309 Wash-

ington Street, Newark. Typically, the evaluating physician is a private practitioner serving the agency on a part-time basis. He reviews the medical, hospital, and laboratory reports and, in conjunction with the vocational evaluator, decides whether the applicant's impairment is disabling under the law.

Does the State agency physician also examine the applicant?

No. He depends entirely on the evidence reported by you and others who have examined or treated the applicant.

Can a person appeal the denial of his claim?

Yes. He is entitled to have his claim reconsidered, submitting any new evidence that may be available. If his claim is again disallowed, he can have it ruled on by a hearing examiner located near his home. As a further appeal, the claimant can request that the decision in his case be reviewed in Washington, D.C., by the Appeals Council of the Bureau of Hearings and Appeals. Then, if he is still dissatisfied, he can file suit in his local U.S. District Court to have the decision reviewed.

What kind of medical report on my patient should I submit?

Submit a standard narrative report, such as you would send any colleague to give a complete medical picture of the patient. This should include the history, and physical and laboratory findings — as much objective data from the patient's chart as possible.

Who pays for my report?

Your patient is legally responsible for providing initial medical evidence in support of his claim. Therefore, he is responsible for any fee you would charge for preparing your report.

Is the initial report from the treating physician all the medical information that the State agency needs to decide a case?

In many cases, yes. Frequently, reports from other treatment source, such as hospitals and clinics are also used. If the evaluating physician requires certain data that were not reported, he may call or write you to find out if you have the needed information in your records.

Suppose I don't have it?

Then the evaluating physician may ask if you wish to provide the information by performing tests or an examination for a fee paid by the Government. Or he may obtain the information by sending the applicant to an independent medical source for examination.

Who are these independent sources?

Generally, other physicians in private practice. Any qualified physician may ask the State agency to place his name on its consultant roster to perform examinations.

How are the consultants' fees set?

The fees are based on a schedule which the agency has worked out with the help of various groups of practicing physicians and advisors.

What is done for applicants who need rehabilitation help?

Every New Jersey patient applying for benefits is considered for possible services by the New Jersey Rehabilitation Commission, Vocational Rehabilitation Program. Such services include counseling, teaching of new employment skills, training in the use of prostheses, and job placement. These services are generally financed from State-Federal appropriations. Additional resources are now provided through social security funds to pay the costs of rehabilitating certain disability beneficiaries.

Do benefits stop when a beneficiary who has not recovered goes back to work?

Generally, not right away. A person who tries to work *despite his medical disability* is usually given a "trial work period" of 12 months of continued benefits. This helps reassure a person who might hesitate to go back to work for fear of losing his benefits before he knows whether he can hold down a steady job. Benefits are stopped at the end of the trial work period only if the beneficiary has shown that

he has regained his ability to do substantial gainful work.

What happens when a beneficiary recovers medically?

His monthly benefit checks are continued for the month of recovery and two additional months. This is to help him adjust financially to being self-sufficient. Then, since he is no longer disabled, his benefits stop. To be sure that beneficiaries continue to qualify for benefits, there are periodic reviews of all cases in which recovery is thought possible.

Does a person who has recovered or returned to work get special consideration if he becomes disabled again?

Yes. If he again becomes disabled within five years, the six-month waiting period normally required before benefits begin is waived. He can immediately become re-entitled to benefits, as long as he is still insured for disability purposes.

Disability Provisions At A Glance

1. Benefits go to disabled workers under 65 and their dependents.
2. A worker is considered disabled if a physical or mental impairment prevents him from doing any substantial gainful work in keeping with his age, education, and work experience.
3. Benefits are payable if the disability has lasted or is expected to last 12 months or longer or to result in death.
4. To acquire disability protection, a person needs to have worked under social security a certain length of time.
5. There are special liberalized eligibility requirements for persons who become disabled by blindness before age 31 and for blind persons aged 55 or over.
6. Benefits begin with the 7th full month of disability.
7. Benefits are the same amount that retirement benefits would be if the worker were 65.
8. Benefits last as long as the disability continues or until retirement benefits start.
9. An adult disabled since before age 18 may be eligible for "childhood disability" benefits if his parent, covered under social security, dies or becomes entitled to retirement or disability benefits.
10. All applicants are considered for vocational rehabilitation services.

John Fitch Plaza

Imipramine can produce an eosinophilia — but this can be without gross clinical symptoms.

Asymptomatic Eosinophilia During Imipramine Therapy

Sydnor B. Penick, M.D. and Russell N. Carrier, M.D./Belle Mead*

Joynt and Clancy[1] reported a case of eosinophilia due to Tofranil® in 1961. This patient had a maximum elevation of total white count to 30,000 with 61 per cent eosinophils. She also had a stiff neck, severe generalized headache, and nausea. We recently observed a patient treated with Tofranil® alone who developed a striking eosinophilia while under hospital observation. This abnormality was picked up only because routine blood counts are done on all patients every two weeks. The patient remained completely asymptomatic.

We here report a 55 year old man who was admitted to the Carrier Clinic on August 3 with a diagnosis of involutional depression. For the month prior to admission he had been depressed and had developed poor appetite and inability to sleep. He had lost 25 pounds in the month prior to admission. He was not suicidal. Past medical history revealed severe varicose veins, with surgery for this last year. On examination he appeared to be extremely depressed, with some agitation; he denied suicidal thoughts. He was fully oriented, memory was intact, and he appeared to be of average intelligence.

His blood pressure was 140/80; pulse was 100 and regular. Positive physical findings were confined to the genitalia where hypospadius was noted. Admission laboratory work revealed a hemoglobin of 15 Grams, a white count of 7,500, polys 63, lymphs 34, monos 2, eosinophils 1. VDRL was non-reactive. Survey chest film, skull films, and thoracic spine films were normal. Urinalysis was within normal limits. Protein bound iodine was 5.5 micrograms per cent. Serum calcium was 5.1 milliequivalents per liter.

His prior treatment had included meprobamate and chlordiazepoxide. He had never received imipramine. The patient was begun on imipramine (25 milligrams a day) and received seven electro-shock treatments. He had some post shock confusion but this improved as did his appetite and sense of well being. Blood count showed a white count of 23,200, 22 polys. 21 lymphs, 1 monos, and 56 eosinophils. The patient received his last dose of imipramine on August 31. He was re-examined on the next day and showed no positive physical findings, notably no splenomegaly, fever, or skin rash. He was completely asymptomatic, maintaining that he felt better than he had at any time during the course of his hospitalization. Additional laboratory work was done at that time. Urinalysis was still unremarkable. Stool was negative for ova and parasites. An eosinophil count on September 7, was 693, with a normal range of 50 to 300, and an L. E. preparation was negative; repeat chest films showed questionable blunting of the right costophrenic angle, which subsided. On September 1st white count was 19,650; 22 polys, 18 lymphs, 60 eosinophils. A sedimentation rate was 8 millimeters with a normal range from 0 to 12. White count, the next day, was 10,700 with 40 per cent eosinophils, on the 3rd it was 12,900 with 25 per cent eosinophils, on the 5th it was 7,300 with 6 per cent eosinophils, and on the 8th of September it was 6,400 with 12 per cent eosinophils. During the course of this entire reaction the patient remained asymptomatic and well.

It is felt very likely that this striking eosinophilia was due to the imipramine. The only other drug the patient had had within one week of the eosinophilia was one dose of Noctec® (chloralhydrate), 15cc at bedtime. He had had phenobarbital, 30 milligrams, 4 times daily for the first week of his admission but none from the 9th of August on. Workup at the time of the reaction revealed no other cause for the eosinophilia and it subsided with the withdrawal of the drug. This case is thought to be somewhat remarkable because of the striking eosinophilia probably related to the imipramine in the absence of any symptoms or physical signs.

* Dr. Penick is medical consultant and director of research at the Carrier Clinic Foundation. Dr. Carrier is the president of the Foundation.

Bibliography

1. Joynt, R. J. and Clancy, J.: Amer. J. Psychiat., 118:170 (1961)

The Carrier Clinic

Most physicians are unfamiliar with the changes in nursing education in the past two decades. Here is a spirited defense of the "hospital school" which, in some quarters, is now considered part of the horse and buggy age. Readers who disagree with Mr. Hoyt are invited to submit letters to the JOURNAL.

Nursing Education And The Hospital School*

Robert S. Hoyt/Perth Amboy

Today there are three ways to prepare for the nursing profession: the two-year program, the three-year program, and the four-year program. The supporters of each program are sure that their own is the best and only way to prepare nurses.

Nursing education is part of over-all changes in the health field. How do we keep our heads about nursing education, and how do we do the best we can as we go along?

Regardless of the *type* of training, in every state, every graduate takes the same state licensing examination to become a registered nurse. And in every state all registered nurses practice under the same Nursing Practice Act and are regulated by the same Board of Nursing. Since there is only one way to become registered, why are there so many different ways to prepare for the licensing examination?

Nursing education began in an organized way in this country after the good ladies who helped the wounded in the Civil War insisted that their communities establish hospitals. Since then the nursing schools developed in response to many pressures, including an ever-growing concern for education and welfare, the burgeoning of careers for women, and rising standards of living that make people demand the best care. But probably the most influential pressure on medical and nursing education was the growth of scientific knowledge.

The early pattern of nursing education was the apprenticeship system. In those days, almost everybody was trained that way. If you wanted to be a lawyer you went to a leading practitioner and "read law" with him. If you wanted to be a shoemaker or a silversmith you apprenticed yourself to an expert shoemaker or silversmith. Those who wanted to be nurses went to a hospital where they could learn by observing and doing. Of course, in those days the body of knowledge was not as great as it is today. Everthing was more of an "art" that you picked up by being on hand when the interesting cases came along. This was considered a privilege. In return you did a great deal of the drudgery and accepted a small stipend along with your room and board. It was part of the times, therefore, that student nurses cooked and sometimes even shoveled coal on the furnace.

We must not lose sight of the wonderful work those nurses did. Those were the days before antibiotics and poliomyelitis vaccine. When a patient had influenza, a nurse had to stay with him night and day, swabbing his body to reduce fever, watching for the "crisis," and so many other things we never hear of today. Not too long ago, we had regular epidemics of poliomyelitis. Nurses had a big job caring

* Based on a talk by Mr. Hoyt, who is Director of the Perth Amboy General Hospital, to the Annual Auxiliary Institute, sponsored by the New Jersey Hospital Association and New Jersey Association of Hospital Auxiliaries, given at New Brunswick, New Jersey on April 6, 1967.

for these victims. Even the iron lung, when it came along, and helpful though it was, took an extraordinary amount of work and nursing care. What distinguished the nurse of that day was her high degree of devotion or commitment to the patient. As compared with today, she didn't have a lot of scientific knowledge, medications, and "hardware" to fall back on. She wanted so much to see her patients improve that, what science didn't provide she made up for with devoted and self-developed know-how. This is often referred to as the "art" of medical or nursing practice.

Then along came World War II. As in so many other fields, military need worked like a hothouse for fast development in medicine and nursing. The war effort needed not only a lot of nurses, but good ones. The army and the navy gave nurses excellent training, good pay, and the rank of officers. Returning after the war to their community hospitals and nursing schools, they wanted the same advancements, the training, salary, and status. Through the National League for Nursing Education, they began to standardize and upgrade nursing schools. They sought to abandon the menial apprenticeship system. They remodeled their educational programs on the college pattern. National accreditation then set guidelines for quality and improvement.

To take advantage of the growth of scientific knowledge they expanded the "science" courses in nursing: anatomy, physiology, microbiology, and chemistry. They became interested in the behavioral sciences too, like psychology and sociology. Because most of the traditional nursing schools did not have the laboratories or specialized faculty for such sciences, they turned to the colleges for this part of their curriculum. Many hospital schools — ours among them — now send their beginning students to a college for such scientific foundation. In our type of program this is now one full year at Union College in Cranford, New Jersey.

Thus involved with junior or community colleges, it was a natural step for nursing educators to develop the idea of the "associate degree" program. If the community college can provide a whole year of academic instruction in the sciences, nurse educators said, why not let them take over the entire program? And while making this change, why not shorten the course from three years to two? And that is how it is that today we have the three different ways to prepare for a nurse career.

When we educate a nurse four types of information are provided:

1. The biologic and social sciences she needs as the basis for patient care.

2. The didactic or academic body of knowledge which makes up today's "practice of nursing."

3. Supervised practice in nursing technics.

4. Whatever additions to the curriculum the particular course happens to include — such as liberal arts, humanities, communications, community relations, and the like.

In the *university* program the student takes a combination of two years of general college education plus two years of majoring in nursing. She gets a degree, usually a bachelor of science in nursing. This degree program, or baccalaureate program, has these advantages: it is certainly the straightest, shortest route to the bachelor's degree; and it is needed for teaching or administrative positions, which often pay higher salaries. In college, the nursing student can enjoy the "campus life" of her contemporaries. She attains the status of a person who has a degree. She receives two years of a general liberal education in addition to her specialized training.

But there are *disadvantages* too. For one thing, the program is expensive. It costs as much as any other college education. But perhaps, the prime objection, from the student's point of view, is that the course takes four years and in those four years the student doesn't begin to spend much time with patients until possibly the third year. Both of these time factors frustrate the student's motivation, since the main reason she wants to be a nurse is to be with patients.

Today when young people have so many careers to choose from, the idea of college

education can be oversold. Colleges, after all, are expensive, overcrowded, and suffering from a critical shortage of faculty.

Let me give you two examples close to me. My son, seeking his master's degree, went to a college widely known for the professors in the field of his choice. But none of his classes had fewer than 70 students. He saw the professors only a few times, and most of his instructors were other graduate students hardly a year ahead of him in training. Another example is the director of our own nursing school. For a Ph.D. degree she matriculated at a major university .The cost was $55 a credit. The class numbered over 120, she saw her professors only a few times and, again, the major part of the instruction came from other graduate students on fellowships.

Similar conditions exist in the undergraduate programs, also. A college program can be most unsatisfying for the student who cannot contend with these conditions. It is not uncommon for the hospital school to take in a student who has withdrawn from such college programs.

Now let us turn to the shortened degree program, the associate degree course or the two-year program. It is commonly given in the "junior" or "community college." The academic part of the course must concentrate on the basic sciences and the didactic material which must be included. A sprinkling of "liberal arts" may be offered, but in a curriculum that aims to reduce training time there is bound to be little opportunity for anything other than the basics. The reduction in the nursing part of the program is achieved by cutting down the amount of practice with the patient. Overall, this is an accelerated course. Its *advantages* are:

1. It is supposed to produce nurses faster.

2. The cost is less than that of a full college course.

3. Acceleration is achieved by eliminating what is termed "unnecessary" repetition.

4. By not providing "living-in" arrangements the program can handle larger numbers.

We in the hospital field are concerned about the *disadvantages* of these short, two-year programs, which we see as:

1. Many students cannot accustom themselves to the pressure of the accelerated rate. This is especially true of the young student.

2. Some two-year programs (those not subsidized by public funds) are quite expensive.

3. The nurse produced in this short course can, and often does, lack the assurance that comes from repeated practice under supervision. In accepting this graduate, the hospital takes the risk of the 6 to 12 months when (although she is an R.N.) she is still acquiring the experience to equal the more assured nurse. This experience is not supervised in an educational program (as it is in the hospital school program) but is acquired at the same time as she should be expected to fulfill her full responsibilities. This leads to questions about the quality of patient care during that period.

Now let us turn our attention to the three-year course given in the hospital or diploma nursing schools. The hospital school is still providing 80 per cent of the nurses today. These nurses are practicing in hospitals, armed forces, public schools, industrial health offices, and public health agencies. They are providing the major part of the nursing care needed today. The hospital-based nursing school offers a three-year course. In an accredited school the science courses are provided in affiliations with colleges, or by college-equivalent faculties in the hospital school. The prime difference is in the clinical practice (actual experience with patients) under the supervision of the faculty. In this kind of school, that part of the course is longer. This program does not attempt — or pretend — to teach the humanities and liberal arts.

In this type of school, students seem to experience much greater satisfaction than in the other kinds. The school is smaller. They enjoy personal relations with the faculty. Most students live at the hospital, become a part of the special world of patients and doctors, and are exposed to much more of the "art" of patient care — the opportunity to develop personal skills and deep commitment through repeated and varied experience at the bedside.

The nurse prepared in an accredited, top-quality school of this type is the *modern* version of the committed, dedicated nurse who saved lives in the influenza and poliomyelitis

epidemics. Anyone who spends any time at all in a hospital knows who these nurses are. They are the ones who take time to understand the patient and his family, who take the difficult assignments, who are there at night and in emergencies, and in blizzards. They are the ones the doctors want at their side when the going gets rough. Finally, this kind of program is usually 50 to 100 per cent less expensive than college programs. Hospitals usually bear the cost of at least $1,700 a year per student, above and beyond what the student pays as tuition.

The major difficulty with this kind of school is that its quality varies. Here in New Jersey, we are fortunate in having about 30 excellent schools. But elsewhere in the country, are some hospital nursing schools that have fallen behind, not so many any more. But as in everything else, the 95 per cent "good guys" suffer from the notoriety given by the 5 per cent "bad guys."

Why can't we just go ahead and have three kinds of programs? The reason is that nursing authorities are trying to eliminate the three-year hospital school, the diploma program. Instead, they propose the other two curricula: the baccalaureate program to produce "professional" nurses, and the two-year schedule to produce "nurse technicians."

The American Nurses' Association has a "position paper" on this subject. Their position is that the hospital school must go. How did they arrive at this position?

Since the war, our world has exploded in knowledge, in education, in professional specialization. The degree has become a passport to status and income, at a time when nurses' salaries were lagging behind others. (They are catching up, incidentally.) The National League for Nursing has reinforced its position by making it more difficult for the hospital school to be accredited and by encouraging the development of the two-year, "associate degree" schools. And the universities have reinforced it by making it increasingly difficult for the graduate of the hospital program to continue her education and to obtain a degree while working. The "diploma graduate" used to be able to earn almost half the credits toward a baccalaureate degree in her hospital school, and then work as a nurse in schedules around her college work for about two years until she earned her degree. These credits have been drastically reduced so that today many diploma graduates have to start almost from scratch to obtain a degree.

The timing of these developments is particularly unfortunate. Because of rising costs for hospitals, many have decided to close their nursing schools. Over the country, 20 a year have been closing. In New Jersey about two a year. And it has also been a time of difficult recruitment of students into nursing. And, of course, young people have so many more other careers to choose from today than ever before. Consequently, there is an enormous shortage of doctors, ministers, teachers, social workers, as well as nurses. The Surgeon General estimates there are 70,000 unfilled nursing positions today — and the 100,000 figure is just over the horizon.

Under these conditions of high cost, difficult recruitment, and criticial shortage of nurses, it doesn't make sense to eliminate the hospital school. The senior and junior colleges simply are not meeting the need for numbers. The hospital schools are still supplying more than three-quarters of the need for nurses in our country today. And by maintaining nursing and other training programs they provide a major educational resource to their communities.

Alert hospitals are taking steps to change or delay this change. Some medical groups and many hospital boards of trustees have passed resolutions supporting the diploma school. The New Jersey legislature has before it a bill† calling for the granting of $600 per student to the nursing schools.

I think the hospital nursing school should and must survive because it turns out the most

† This bill (S-409) was signed by Governor Hughes on May 22, 1967

nurses and the most dedicated nurses. Next to patient care, education is one of a hospital's most important services to its community.

A few months ago, a terrible blizzard struck the mid-west. In the Chicago area, some hospitals were almost 100 per cent isolated for three, four, and even five days. The hospitals that continued patient care at a high level were the hospitals that had nursing schools right on the premises. Some hospitals that did not have nursing schools had to refuse admissions.

In my own hospital — and I am sure in others in New Jersey — when we were snowed in this winter, our students helped to cover the day, evening, and night shifts. We talked to them about this on their way to their stations. They were smiling and alert.

"What's all the excitement about?" we asked.

"We're needed," they said over and over again, and they beamed.

And when the emergency was over, they were happy and proud. And we were too.

530 New Brunswick Avenue

Can Group Therapy Help The Smoker?

Group therapy helps some people quit smoking. But no matter what kind of therapy is used, relatively few who attend the sessions seem to be able to kick the habit.

When four types of group-therapy were tried in Philadelphia, all had about equal success; but only 26 per cent of the smokers had given up the habit after one week, and only 18 per cent did not smoke one year later, says a report in *Envionmental Health,* February 1967. These findings do not give much support to major investment in small-group smoking withdrawal programs.

The four types of group therapy tested were:

(1) The Educative Group — The leader was a widely known thoracic surgeon and ex-smoker who presented facts regarding the relationship between smoking and several diseases.

(2) The Therapy Group — This group used psychologic therapeutic methods to "talk out" their smoking problem and to attempt to reach decisions to stop smoking.

(3) A Combination Group—Used features of both of the above groups.

(4) The Five-Day Therapy Group—Organized in association with the Seventh-Day Adventist Church. The group met five consecutive evenings, and again 10 and 17 days later. Emphasis was on some of the psychologic technics used in the therapy group, and on smoking's threat to health. The "time element" of stopping smoking within a certain number of days was stressed. This group had slightly better results than the others, but it had a high dropout rate (70 attended the first meeting; 35 attended the last two); only 27 per cent of the participants had stopped smoking when queried 15 months later.

"The results demonstrate once again the wide gap . . . between the conscious wish to stop smoking and the ability to do so," the article said. "The strength of their wish to quit is reflected in the sacrifices which people had to make to participate in these groups. Yet, this high motivation paid dividends to only a few successful ex-smokers."

STATE ACTIVITIES

SPECIAL/LIAISON REPRESENTATIVES 1967-1968 SPECIAL COMMITTEES

Academy of Medicine of New Jersey

(1) Board of Trustees/Liaison Committee
(Liaison requested by Academy — 6/19/66)
Joseph P. Donnelly, M.D., *Chairman* . . . Jersey City
Thomas C. DeCecio, M.D. Cliffside Park
Nicholas E. Marchione, M.D. Vineland

(2) Post-Graduate Medical Education Study Committee
(Representative requested by Academy — 11/15/64)
Sherman Garrison, M.D. Bridgeton

American Medical Association— Education Research Foundation

(Liaison requested by AMA — 10/7/51)
Chairman, Medical Student Loan Fund Committee
Luke A. Mulligan, M.D. Leonia

Audit Review Committee (1966-1967 Audit)

(Appointed annually by Board to review previous year's audit)
Joseph R. Jehl, M.D., *Chairman* Clifton
Louis F. Albright, M.D. Spring Lake
Nicholas E. Bertha, M.D. Wharton
Frank J. Hughes, M.D. Gloucester
Nicholas E. Marchione, M.D. Vineland
Consultants:
Samuel J. Lloyd, M.D., *Treasurer* . . . Trenton
Thomas C. DeCeco, M.D., *Chairman, Finance and Budget Committee* Cliffside Park

Bicentennial History

(Committee appointed to expedite distribution of history — 5/12/67)
Emanuel M. Satulsky, M.D., *Chairman* Elizabeth
Richard I. Nevin, *Executive Director* Trenton

Blood Bank Commission of New Jersey

(1) Formation of Commission authorized by 1953 House of Delegates
Authorized agent of MSNJ in approved Blood Bank Programs

(2) Appointment of two representatives requested by Commission — 4/5/54
Jerome G. Kaufman, M.D. Maplewood
John J. Torppey, M.D. Newark

Blue Cross-Blue Shield Plans of New Jersey, Permanent Committee on

(Appointment of committee requested by MSP — 4/16/60)
Frank J. Hughes, M.D., *Chairman, Board of Trustees* Gloucester
Louis K. Collins, M.D., *President* Glassboro
Richard I. Nevin, *Executive Director* Trenton

*Nicholas A. Bertha, M.D. . . . Wharton
Equal representation from:
Medical Service Plan of New Jersey
Hospital Service Plan of New Jersey
New Jersey Hospital Association

*for 1967-68 only

Board of Control, Department of Institutions and Agencies

(Appointed by Governor for 8-year term)
Frank J. Hughes, M.D. (June 1971) Gloucester

Board of Nursing, New Jersey State

(Liaison requested by Board of Nursing — 11/21/65)
Jesse McCall, M.D. Newton

Bureau of Investigation, Department of Law and Public Safety

(Cooperating committee requested by Department of Law and Public Safety — 9/61)
Board of Trustees

Cardiac Advisory Panel to Director of Motor Vehicles

(Panel requested by Special Commission on Traffic Safety — 9/17/61 . . . appointed by the Director of Motor Vehicles)
Jerome G. Kaufman, M.D., *Chairman* . . . Maplewood
Louis F. Albright, M.D. Spring Lake
Jesse McCall, M.D. Newton
James G. Kehler, M.D. Woodbury

Chamber of Commerce Legislative Conferences

(Invited by Chamber — 1/15/61)
Richard I. Nevin, *Executive Director* Trenton

Chronic Sick, State Advisory Council

(Commissioner of Health requested MSNJ submit names to Governor — 10/16/60 . . . appointed by Governor for 3-year term)
William D. Kimler, M.D.
(December 1967) Haddon Heights

Civil Defense Organization, Liaison With State

(Liaison established by MSNJ — 5/22/55)
Jack R. Karel, M.D., *Chairman, Emergency Medical Care Committee* Hillside

Crippled Children Commission, State

(Appointed by Governor for a 5-year term)
Frederick G. Dilger, M.D. (May 1971) Hackensack

Diabetes Detection Drive

(Liaison representative for annual drive — co-sponsored by State Department of Health, New Jersey Diabetes Association, and MSNJ — appointed at request of Commissioner of Health — 5/16/54)
John J. Torppey, M.D. Newark

Disputed Claims, Advisory Committee to Review MSP and HSP

(Established at request of MSP — 8/21/60 — Quorum: 4 members
1st District —
Ralph M. L. Buchanan, M.D., *Chairman* Phillipsburg
Robert F. Zimmerman, M.D. Morristown
2nd District —
John J. Bedrick, M.D. Bayonne
Robert A. Cosgrove, M.D. Jersey City

3rd District —
John S. VanMater, M.D. New Brunswick
John A. Kinczel, M.D. Trenton
4th District —
John C. Clark, M.D. Asbury Park
Reuben L. Sharp, M.D. Camden
5th District —
A. Guy Campo, M.D. Westville
Nicholas E. Marchione, M.D. Vineland

Educotion, State Department of

(Liaison requested by the Assistant Commissioner of Education — 9/21/58)

William J. Farley, M.D., *Chairman, Special Committee on Child Health* Nutley

Emotionally Disturbed Child, Advisory Council to Department of Educotion

(Nomination of 3 names requested for appointment of 1 by new Commissioner)

William L. Rumsey, Jr., M.D. Elizabeth
William J. Farley, M.D. Nutley
Albert Schmidt, M.D. Sea Girt

Epilepsy, Advisory Panel to Stote Director of Motor Vehicles

(Established at request of Director of Motor Vehicles — 7/29/66)

Referred to Chairman of Council on Mental Health for recommendations

Executive Committee

(Provided in the Bylaws, Chapter IV, Section 5 [b])

Louis K. Collins, M.D., *President* Glassboro
John F. Kustrup, M.D., *President-Elect* Trenton
Nicholas A. Bertha, M.D., *First Vice-President* Wharton
Emanuel M. Satulsky, M.D., *Second Vice-President* Elizabeth
Frank J. Hughes, M.D., *Chairman Board of Trustees* Gloucester

Fluoridotion, Joint Committee on

(Established at request of the State Department of Health)

Edwin H. Albano, M.D. East Orange
John P. Coughlin, M.D. Jersey City
Equal representation from:
State Department of Health
New Jersey State Dental Society

Foreign Interns, Committee to Study Licensure of

(Established by MSNJ — 12/18/66 — to work with the Board of Medical Examiners)

Louis K. Collins, M.D., *Chairman* Glassboro
A. Guy Campo, M.D. Westville
Jesse McCall, M.D. Newton

Headquarters, Investigation of Future

(Committee established by Board — 6/19/66)

Nicholas A. Bertha, M.D., *Chairman* Wharton
Samuel J. Lloyd, M.D. Trenton
Emanuel M. Satulsky, M.D. Elizabeth

Heolth Careers Service, Resource Persons to New Jersey

(Liaison established at request of Health Careers Service — 7/19/64)

Presidents of Component Societies

Heolth Facilities Plonning Council

(MSNJ invited to nominate 3 members for the Board of Trustees — 2/16/64 . . . appointed by Council to serve for a 3-year term)

Louis F. Albright, M.D. (1970) Spring Lake
John F. Kustrup, M.D. (1969) Trenton
Jesse McCall, M.D. (1968) Newton

Health Insurance Conference

(Committee established at request of Health Insurance Council — 3/24/57)

Marcus H. Greifinger, M.D., *Chairman* Newark
Jerome G. Kaufman, M.D. Maplewood
Fred A. Mettler, M.D. Blairstown
Louis K. Collins, M.D., *President* Glassboro
John F. Kustrup, M.D., *President-Elect* Trenton
Nicholas A. Bertha, M.D., *First Vice-President* Wharton
Emanuel M. Satulsky, M.D., *Second Vice-President* Elizabeth
Richard I. Nevin, *Executive Director* Trenton

Health, Stote Deportment of

(Liaison requested by Commissioner of Health — 6/6/54)

John P. Coughlin, M.D., *Chairman Council on Public Health* Jersey City

Heort Disease, Concer, and Stroke

University City Science Center, Philadelphia
(Established at invitation of University City Science Center — 12/65)

Louis K. Collins, M.D. Glassboro

Historion-Archivist

(Created at the suggestion of the Executive Director — 1/13/57)

Morris Saffron, M.D. (Appointed May 1967) Passaic

Hospitol Advisory Council, Stote Department of Institutions ond Agencies

(Appointed by the Board of Control for a 4-year term)

C. Byron Blaisdell, M.D. (December 1967) Asbury Park
Luke A. Mulligan, M.D. (December 1969) Leonia

Hospital Service Plon Boord of Trustees

(Provided in HSP Bylaws)

Louis K. Collins, M.D., *President* Glassboro

House Mointenance, Staff Policies, ond Personnel Relations

(Special committee created by Board of Trustees — 9/21/58)

Louis K. Collins, M.D., *President, Chairman* Glassboro
John F. Kustrup, M.D., *President-Elect* Trenton
Marcus H. Greifinger, M.D., *Secretary* Newark
Samuel J. Lloyd, M.D., *Treasurer* Trenton
Frank J. Hughes, M.D., *Chairman, Board of Trustees* Gloucester
Thomas C. DeCecio, M.D., *Chairman, Committee on Finance and Budget* Cliffside Park
Richard I. Nevin, *Executive Director* Trenton

Industriol Sofety Boord, New Jersey

(Appointed by the Governor for 1 year term — 10/16/66)

Joseph A. Lepree, M.D. Elizabeth

Institutions and Agencies, State Department of
(Liaison established 7/16/61)
Frank J. Hughes, M.D. Gloucester

Intro-Hospital Infections, Joint Committee on
(Established at request of Commissioner of Health — 4/8/62)
Edwin H. Albano, M.D., *Chairman* East Orange
Lawrence Gilbert, M.D. Newark
Thomas K. Rathmell, M.D. Trenton
Eugene H. Kain, M.D. Camden
Equal representation from:
State Department of Health
New Jersey Hospital Association
New Jersey State Nurses' Association

Jempoc, Conference Committee With
(Established at request of JEMPAC — 6/25/67)
Jesse McCall, M.D., *Chairman, Council on Legislation* Newton
Nicholas E. Marchione, M.D., *Chairman, Council on Medical Services* Vineland
Emanuel M. Satulsky, M.D., *Second Vice-President* Elizabeth

Judiciory and Bar, Conference Committee on Inter-Relotions with the
(Established at invitation of Supreme Court — 11/17/63)
John P. Coughlin, M.D. Jersey City
E. Vernon Davis, M.D. Mount Holly
Joseph P. Donnelly, M.D. Jersey City
Joseph M. Gannon, M.D. Plainfield
Marcus H. Greifinger, M.D. Newark
Jerome G. Kaufman, M.D. Maplewood
Samuel J. Lloyd, M.D. Trenton
Nicholas E. Marchione M.D. Vineland
Jesse McCall, M.D. Newton
Fred A. Mettler, M.D. Blairstown
Richard I. Nevin, *Executive Director* Trenton
Equal representation from:
Supreme Court Committee on Relations with the Medical Profession

Legislation
(1) Federal Keymen
(Mechanism established by MSNJ — 4/4/54 . . . to serve as official intermediaries between MSNJ and the Federal Legislators)
15 Congressional District Keymen
1 Senatorial Keyman
(2) State Keymen
(Mechanism established by MSNJ — 7/13/52)
Keymen in 14 Senatorial Districts/21 Component Societies

Medical Assistants, New Jersey Associotion of
(Liaison requested by Association — 9/15/63)
Aaron J. Heisen, M.D. Trenton

Medical-Hospitol-Nursing Conference (Tri-Partite)
(Liaison established by MSNJ — 1/13/57)
Louis K. Collins, M.D., *President* Glassboro
John F. Kustrup, M.D., *President-Elect* Trenton
Joseph R. Jehl, M.D., *Immediate Past-President* Clifton
Richard I. Nevin, *Executive Director* Trenton
Equal representation from:
New Jersey Hospital Association
New Jersey State Nurses' Association

Medical Liaison Committees
(High-level conference groups for discussion and consideration of items of mutual interest)
(1) Medical-Dental
(Liaison requested by the Dental Society — 6/10/51)
(2) Medical-Hospital
(Liaison established by MSNJ — 10/25/53)
(3) Medical-Legal
(Liaison established by MSNJ — 10/25/53)
(4) Medical-Nursing
(Liaison established by MSNJ — 4/4/54)
(5) Medical-Osteopathic
(Liaison requested by Osteopathic Association — 9/17/61)
(6) Medical-Pharmaceutical
(Liaison established by MSNJ — 7/26/53)
Louis K. Collins, M.D., *President* Glassboro
John F. Kustrup, M.D., *President-Elect* Trenton
Joseph R. Jehl, M.D., *Immediate Past-President* Clifton
Richard I. Nevin, *Executive Director* Trenton
(Where number of representatives from other organization is larger than number of MSNJ representatives, the latter will be increased from the Presidential Officers to equal the former.)

Medical School in South Jersey, Committee to Assist in the Implementotion of Legislation to Estoblish o
(Established by Board — 5/17/67 — Appointments by President)
Louis K. Collins, M.D., *President, Chairman* Glassboro
A. Guy Campo, M.D. Westville
Joseph P. Donnelly, M.D. Jersey City
Sherman Garrison, M.D. Bridgeton
Frank J. Hughes, M.D. Gloucester
Jerome G. Kaufman, M.D. Maplewood
John F. Kustrup, M.D. Trenton
Fred A. Mettler, M.D. Blairstown

Medicol Schools in New Jersey, Committee on Development of
(Established by Board — 9/20/64)
Joseph R. Jehl, M.D., *Chairman* Clifton
Louis K. Collins, M.D. Glassboro
Joseph P. Donnelly, M.D. Jersey City
Sherman Garrison, M.D. Bridgeton
Jerome G. Kaufman, M.D. Maplewood
Fred A. Mettler, M.D. Blairstown

Medical-Surgical Plan Board of Trustees
(Provided in MSP Bylaws)
Louis K. Collins, M.D., *President* Glassboro

Medicare Law (P.L. 89-97)
(Assigned by the Board — 10/17/65 as indicated below)
(1) Overall responsibility to study and provide recommendations concerning the Medicare Program
Council on Medical Services
Consultants to the Council on Medical Services:
Louis K. Collins, M.D., *President* Glassboro
John F. Kustrup, M.D., *President-Elect* Trenton
Jesse McCall, M.D., *Chairman, Council on Legislation* Newton
John P. Coughlin, M.D., *Chairman, Council on Public Health* Jersey City
Matthew E. Boylan, M.D., *Chairman, Committee on the Chronically Ill and the Aging* Jersey City
Frank J. Hughes, M.D., *Member, New Jersey Board of Control* Gloucester

(2) Liaison representative to State Department of Health
(Established by MSNJ — 1/16/66)
David Eckstein, M.D. Trenton
(3) Liaison representative to State Department of Institutions and Agencies
(Established by MSNJ — 1/16/66)
Francis J. Benz, M.D. Chatham
(4) Home-Hospital-Nursing Care
(Liaison established by MSNJ — 3/20/66)
Matthew E. Boylan, M.D. Jersey City

Membership Directory

(Special Committee established by Board — 11/19/61)

Marcus H. Greifinger, M.D., *Chairman* Newark
John J. Bedrick, M.D. Bayonne
Nicholas A. Bertha, M.D. Wharton
George B. Sharbaugh, M.D. Trenton
Joseph R. Jehl, M.D. Clifton
Richard I. Nevin, *Executive Director* Trenton
Robert H. Lambert, *Business Manager* Trenton

Motor Vehicles, State Division of

(Liaison established at the request of the Division — 4/16/61)

R. Winfield Betts, M.D. Medford

Neurological Diseases, Advisory Council to New Jersey Consultation Service for Convulsive Disorders

(Liaison established — 7/19/64)

Robert S. Garber, M.D. Belle Mead

New Jersey College of Medicine and Dentistry, Student AMA

(Liaison requested by New Jersey Chapter — 1/26/60)

Joseph P. Donnelly, M.D. Jersey City

Nursing, Governor's Task Force on

(MSNJ representatives named to the Task Force)

Jesse McCall, M.D. Newton
William P. Mulford, M.D. Beverly
Richard I. Nevin, *Executive Director* Trenton

Nursing Education and Recruitment, Permanent Committee on

(Established by direction of 1963 House of Delegates)

Jesse McCall, M.D., *Chairman* Newton
George E. Barbour, M.D. Somerville
William P. Mulford, M.D. Beverly
Lewis E. Savel, M.D. South Orange
Richard I. Nevin, *Executive Director* Trenton
Equal representation from:
New Jersey Hospital Association
New Jersey League for Nurses
New Jersey State Nurses' Association
Administrators of Nursing Schools
Advisors (2) from State Department of Education

Nutrition Council, New Jersey

(Liaison established by MSNJ — 12/19/54)

S. William Kalb, M.D. Newark

ODMC (Office of Dependent's Medical Care)

(1) Fiscal Agent
(Designated, upon request of MSP — 7/21/63)
Medical-Surgical Plan of New Jersey
(2) Special Committee on
(Established by MSNJ — 9/9/56)
Nicholas A. Bertha, M.D., *Chairman* . . Wharton
George E. Barbour, M.D. Somerville
Thomas C. DeCecio, M.D. Cliffside Park
Joseph R. Jehl, M.D. Clifton

Osteopathic Question, Special Committee on

(Requested by AMA — 11/19/62 . . . Reactivated by Board — 7/18/65)

Emanuel M. Satulsky, M.D. *Chairman* Elizabeth
Louis K. Collins, M.D. Glassboro
John J. Bedrick, M.D. Bayonne

Parents and Teachers, New Jersey Congress of

(Liaison requested by MSNJ's Committee on Child Health — 12/20/64)

Joseph R. Jehl, M.D. Clifton

Pension Plan, Special Committee on

(Established by Board — 5/22/55 . . . Duties outlined in Article III of Pension Plan Agreement)

Thomas C. DeCecio, M.D., *Chairman, Committee on Finance and Budget* . . . Cliffside Park
Louis K. Collins, M.D., *Chairman, Special Committee on House Maintenance, Staff Policies, and Personnel Relations* Glassboro
Samuel J. Lloyd, M.D., *Treasurer* Trenton

Project Hope, Special Committee on

(Special Committee created by Board, to implement Resolution #3 adopted by the 1966 House of Delegates — 5/18/66)

Thomas C. DeCecio, M.D., *Chairman* . . . Cliffside Park
Nicholas A. Bertha, M.D. Wharton
Harold L. Colburn, Jr., M.D. Mount Holly

Public Health Association, New Jersey

(1) Membership authorized by Board — 11/15/59
Joseph R. Jehl, M.D., *Delegate* Clifton
Richard I. Nevin, *Alternate* Trenton
(2) Animal (Medical) Research
(Liaison representative requested by Association — — 4/17/66)
Edwin H. Albano, M.D. East Orange
(3) Medical Care Committee
(Association requested physician to serve as chairman of its Medical Care Committee — 2/24/65)
John J. Bedrick, M.D. Bayonne

Public Health Council, State Department of Health

(Nominations for appointment by Governor . . . requested — 9/20/64)

Henry L. Drezner, M.D. Trenton

Quackery, Committee on

(Established at the request of the AMA — 11/15/64)

Thomas C. DeCecio, M.D., *Chairman* . Cliffside Park
Henry J. Mineur, M.D. Cranford
Charles B. Norton, M.D. Woodstown

Radiation Protection Commission, Consultant to New Jersey

(Nomination for appointment to Commission requested — 7/18/65

Bernard M. Schnur, M.D. Trenton

Radiation Protection Commission, New Jersey

(Two consultants in nuclear medicine requested by the Commission 11/66)

Frank Schell, M.D. Paterson
John Thompson, M.D. Montclair

Rehabilitation Commission, New Jersey State
(Liaison requested by MSNJ Committee on on Rehabilitation — 5/65)
Carl A. Maxwell, M.D. Phillipsburg

Safety Council, New Jersey State
(Provided in Council Bylaws)
Louis K. Collins, M.D., *President* Glassboro
Joseph A. Lepree, M.D.,
President's representative Elizabeth

Selective Service System,
New Jersey Chairman of Advisory Committee to
(Nomination for appointment by National Advisory Committee requested by committee — 11/19/61)
Jesse McCall, M.D. Newton

Statues Related to the Practice of Medicine and Surgery in New Jersey, Committee to Review
(Established by MSNJ to implement substitute for resolutions 7 and 8, 1967 House)
Nicholas A. Bertha, M.D., *Chairman* Wharton
Samuel J. Lloyd, M.D. Trenton
Thomas C. DeCecio, M.D. Cliffside Park
Richard I. Nevin, *Executive Director* Trenton
Robert M. Backes, *Legal Counsel* Trenton
E. Powers Mincher, *Legislative Analyst*....Pennington

Tuberculosis Council, New Jersey State
(Appointment of representative to council requested by Commissioner of Health — 2/19/61)
John P. Coughlin, M.D. Jersey City

Welfare Council, New Jersey
(Representative to plan meetings for annual conference on social welfare requested by council — 5/13/66)
John J. Bedrick, M.D. Bayonne

Widows and Orphans of Medical Men of New Jersey, Society for Relief of
(Liaison requested by Society — 5/17/59)
Joseph R. Jehl, M.D. Clifton

Professional Courtesy

Are you under any ethical obligation to treat without fee, a nurse's husband or a doctor's daughter-in-law? Should you refuse a fee for taking care of a physician if he has insurance coverage that will reimburse him or you? If you have to spend an hour out of every busy day in rendering service to an M.D. will this justify your expecting him to pay you a fee? In these days when so many medical students are married, does the professor of obstetrics in the school have to deliver all their wives free? If they send him a gift—well, how many desk pads, electric clocks, or sterling silver punch bowls can you use?

To the rescue, comes the Judicial Council of the AMA. Here, in a June 17 (1967) release, is what they say.

"The custom of professional courtesy embodies the ancient tradition of fraternalism among physicians in the art which they share, and their concern to apply their learning for the benefit of one another as well as their patients. The Judicial Council reaffirms and endorses the principle of professional courtesy as a noble tradition adaptable to the changing scene of practice.

"Professional courtesy is not a rule of conduct to be enforced under threat of penalty. It is the responsibility of the physician to determine for himself and within his own conscience to whom and the extent to which he will allow a discount from his usual and customary fees for the professional services he renders; and to whom he renders such services without charge as professional courtesy.

"The following guidelines are offered as suggestions to aid physicians in resolving questions related to professional courtesy.

"1. Where professional courtesy is offered by a physician but the recipient of services insists upon payment, the physician need not be embarrassed to accept the fee.

"2. Professional courtesy is a tradition that applies solely to the relationship that exists among physicians. If a physician or his dependents have insurance providing benefits for medical or surgical care, a physician who renders such service may accept the insurance benefits without violating the traditional practice of physicians' caring for the medical needs of colleagues and their dependents without charge.

"3. If a physician is called upon to render services to other physicians or their immediate families with such frequency as to involve a significant proportion of his professional time, or in cases of long-term extended treatment, fees may be charged on an adjusted basis so as not to impose an unreasonable burden upon the physician rendering services.

"4. Professional courtesy should always be extended without qualification to the physician in financial hardship, and members of his immediate family who are dependent upon him."

Funeral Directors Seek Cooperation with Physicians

The Funeral Directors' Association of Essex and Union Counties suggests the following procedures regarding the completing of death certificates by physicians:

Wherever possible physicians, whose patients expire in hospitals during the night, make an earnest effort the next morning, while in the hospital, to complete that portion of the death certificate pertaining to the medical certification. The law requires the physician to sign the death certificate within 24 hours after death. After signing, the certificate can be left at the front desk of the hospital, the Medical Record Room, or some other designated area. The funeral director will call for the certificate at the hospital rather than at the doctor's office. This will eliminate many interruptions during regular office hours.

Occasionally a deceased patient is the only patient a doctor may have had in a hospital at that time. To return to the hospital the next morning would be inconvenient. Under these circumstances, we have no alternative — we must go to the doctor's office.

In deaths occuring at home (other than Medical Examiners cases) a signed certificate could be left at the home after death has been ascertained. The advantage to the physician would be that there is no interruption of office hour routine and one less funeral director in the office. This will same time for the physician.

We have no objection to going to the office for signatures. We do, however, expect some consideration by not having to wait our turn in the same manner a patient waits.

Everyone is entitled to a few days off in addition to vacation, but at times we are left in a quandary as to who will sign the certificate during the absence of the attending physician if no other doctor has access to the medical records.

The completed death certificate is filed with the local health department in order to obtain a burial or cremation permit. This must be done before a burial or cremation takes place. Failure on our part to secure the permit will result in a fine up to $100. In addition, we are subject to charges being brought against us. On many occasions we are called on to prepare a cadaver for shipment out of state or out of the country. With train, airplane or ship departures to make, time is of the essence. Railroads require the shipment to be at the station at least one hour before departure time; airlines require two hours; and ships even longer.

We hope that a better understanding and agreement will be reached. We both serve mankind — each in a different way — but we do serve.

We, as funeral directors, are not the paragon of perfection we realize. Therefore, if practicing physicians have any suggestions or complaints we want to know about them. Only by being made aware of shortcomings can we correct them.

(Prepared by Frederick J. Trepkau of Orange, a member of the Board of Directors of the New Jersey State Funeral Directors' Association)

Drug Law Seminar

On April 14, 1967, a seminar on the Food and Drug Law was held in Chicago. The meeting included representatives of the Federal Trade Commission, the pharmaceutical industry, and the Food and Drug Administration (FDA), as well as a professor of law at Temple University. The FDA panel discussed proposed regulations affecting the labeling and advertising of drugs. By law, all proposed federal regulations and revisions are published in the Federal Register. Public hearings are then held and the proposed Regulations may be altered as a result of such hearings. The present proposed revisions of Regulations are

being submitted to additional public discussion prior to publication in the Federal Register. This seminar was one of the additional public hearings prior to publication. Comments from the audience were recorded for later study by FDA.

The new Regulations will achieve a unity of concept in labeling and advertising with three options at graded levels such as (1) the reminder advertisement, (2) the label or notice with brief summary of information, and (3) the label or package insert with full disclosure. In a 1, 2, or 3 page advertisement, there may be a provision for a brief summary, and a requirement for a middle level ("brief summary discussion") for longer advertisements. The lowest level ("brief summary") may be authorized for promoting a drug for only one of its indications. Any advertisement in which the claims are expressed briefly may give the side effects and contraindications briefly also. But if claims are extensively detailed, the rest of the disclosure must be extensive.

In the Regulations when "contraindications, adverse effects, and side effects" are mentioned, the phrase refers to *all* this type of information in the writeup whether or not listed under formal headings. Fair balance is to be sought in an advertisement. The warnings must not be diluted by use of a number of pages. The advertisement as a whole should present the summary of adverse effects whether or not a separate section contains warnings.

"Brief summary" consists of a listing of the disadvantages — the "typical brief *discussion* summary" is the same only amplified by discussion. The third level of information ("full disclosure") was not contemplated for advertising.

The Revised Regulations will contain definitions of "untrue," "false," and "lacking in balance," including specific examples. They will also clarify the specifications for the three levels of graded disclosures and specify the limitations of reminder advertisements.

The 3-page cutoff point may be altered by content of the three pages, or may be set at 4 pages in recognition of the fact that inserts are usually 2 or 4 pages. One of the FDA's compliance officers emphasized that the goal of the FDA was to promote good health and not to prosecute. The FDA realized that the only source of drug information for most M. D.'s was the pharmaceutical industry. This imposes a weighty responsibility on the industry. The rule of thumb of the FDA on any question of drug information is, "Is this the kind of information and is it *all* the information you would want the doctor to know who was treating you or your loved ones?" Mailing envelopes containing drug warnings will be coded as to color and prominently printed to make it more likely that the physician sees them.

A representative of Arnar-Stone Laboratories, spoke on "The Role of Pharmaceutical Advertising." He emphasized the desire of the industry to have legal controls based on reasonable and predictable terms with the avoidance of rulings by whims of bureaucrats. He stressed the educational mission of drug advertising and said that good advertising shortened the gap between the acquisition of new knowledge and its application in the doctor's office. He also pointed out that the trend to imparting information on side effects preceded the late Senator Kefauver's investigation. He recognized that it was natural for advertisers to emphasize advantages; but he insisted that in drug advertising this was unwise if done out of proportion, since most doctors develop a "mental callus" against exaggerated claims and tend to resist all information about a drug which is 'oversold.'

He listed the 7 deadly sins of drug promotion:

1. Extension or distortion of the claims for usefulness beyond that approved in the product's final printed labeling.

2. Featuring a quotation from an article in a way which misleads by inaccurately implying that the particular study is representative of much larger and general experience with the drug.

3. The selection of poor quality research papers making statements favorable to the product while ignoring contrary evidence from much better research.

4. Quotation out of context or a seemingly favorable statement by an authoritative figure but omission of unpleasing data from the same article.

5. Quoting from an obviously authoritative source while failing to quote from other differing experts in the same field with the result that a properly balanced view is not given.

6. Featuring data from papers that report no side effects, but failing to quote from others that do.

7. Continuing to run advertisements which are constructed from data previously valid but rendered obsolete or false by more recent research.

Mr. Sutton advocated the creation of a third party "referee" type of group of experts to advise both industry and the regulating agencies. The Professor of Law deprecated the practice of calling attention (in advertising) to the defects of rival drugs. This creates fears in the minds of lay persons. It is undignified, and promotes litigation. He said that advertisements may 'puff' a product a little, in so far as effectiveness is concerned, but never in relation to safety. On over-the-counter drugs, advertisements may say 'relieves quickly' but not 'quicker.' The terms 'cure' and 'permanent relief' are forbidden. Claims made by over-the-counter drugs are allowed to be slightly more explicit in diseases such as the common cold and psoriasis in which treatment by a physician is not very effective. Testimony by a patient may mention common symptoms such as pain, stiffness, and fatigue; but may not mention diagnoses. It may not mention 'cure' but can speak only of change in symptoms.

The attorney listed methods by which the FDA may enforce compliance as varying from a warning (or advisory) letter, to a demand to show cause why a defendant should not be charged, to seizure of a product, and up to injunction proceedings. FDA favored the "seizure" method since it gave the manufacturer an opportunity to react immediately and revise the challenged advertising copy. Federal Trade Commission advisors on advertising need not have personal experience with a product. The FTC at times considers not the wording of the advertisement, but its effect on the laymen. The FDA does not regard the ignorance of a manufacturer (in regard to omission of data) as a defense. They expect the manufacturer to be informed.

Print size is important in labeling and advertising. It is unacceptable to put advantages in large size and disadvantages in small size. Nor is it acceptable to reduce a full-page advertisement to a size small enough to make it illegible. All varieties of labeling must be complete disclosures except in medical journals and in drug exhibits where brief summary is sufficient.

Reprints containing claims in excess of that allowed on labeling may not be distributed even when accompanied by a proper insert. All reprints that contain only authorized information should be accompanied by a proper insert. Results on study on animals must never be quoted in such a way as to infer that the results are applicable to humans.

—Frank B. Ramsey, M.D., President
State Medical Journal Advertising Bureau

Medicine And Religion

The swift growth and universal acceptance of the American Medical Association's Medicine and Religion Program has proved it is fulfilling the national need to establish a dialogue between the physician and clergy, says Milford O. Rouse, M.D., AMA president-elect.

He urged physicians to invite the clergyman to become a part of the health team. Dr. Rouse made the appeal at the meeting of State Medical Society Medicine and Religion Committee Chairmen recently held in Chicago. "This has been one of the most universally well received programs ever launched by the AMA," Dr. Rouse said. "It is one of the only programs, in my experience, which has never been criticized."

The AMA's Department of Medicine and Religion was established in 1961. Its goal is to bring the clergyman and physician together to provide total care and treatment of the patient, recognizing that man is spiritual, emotional, and social, as well as physical. Recognizing the importance of the "whole being"

concept, the AMA Board of Trustees established a Committee on Medicine and Religion consisting of a chairman, 10 physicians, and 10 clergymen. Today there are 48 state and 622 county society Medicine and Religion Committees throughout the nation.

At the national meeting of committee chairmen it became clear that the program is taking on a new emphasis, shifting from the organizational to the operational phase. This change is reflected in the program presented by the AMA Committee on Medicine and Religion at the AMA's Annual Convention, June 1967. This year's program dealt with specific problems, such as the unwed mother, contraceptives and the coed, abortion, and alcoholism.

The change also was apparent from reports about state committee activities. Rev. Richard K. Young, chairman of the Subcommittee for Seminary Education, said there is a real interest and need to move the program to the seminary level. William P. Williamson, M.D., said there also is a "genuine need" for this type program at the graduate level of medical education. Due to the successful experiences with formal graduate seminars on medicine and religion, he suggested that such programs be more widely instituted.

The rapid growth and universal interest in the medicine and religion program is providing a major challenge to the established committees to provide continuity and planning. "The program has mushroomed so fast we only have a limited knowledge of what has been accomplished," George W. Petznick, M.D., chairman of Subcommittee on State and County Programs, said. Of "utmost importance'" in maintaining the momentum of this "dynamic program," he said, is providing continuity and guidance in planning meetings at the state and local levels.

Winslow G. Fox, M.D., chairman of the Michigan State Medical Society Committee on Medicine and Religion, agreed. Because of the swift growth of the programs at the state level, the state committees "must concentrate on providing continuity." He said the determination must be made as to what has been accomplished and what remains to be done in establishing a dialogue between the physician and clergy.

R. Paul Ferguson, M.D., chairman of the Iowa Medical Society committee, said the medicine and religion program at the national and state levels is now "tooled up and a going concern." Success now depends on bringing physicians and the clergy together at the patient's bedside, he said.

The program already has demonstrated that both the clergyman and physician recognize the need for this interaction, but he suggested that the physician must provide the initiative to bring the two professions together.

New Jersey Hospital Radio Network

Severe storms ravaged our coast in 1962, isolating several counties. Hospitals in the cut-off areas needed supplies, extra nursing and medical help, and even assistance in evacuating patients. Because communications were disrupted, no call for aid could be put through. This disaster was midwife to an idea for a radio communications network between hospitals.

In 1961, the Federal Communication Commission had authorized certain FM channels for hospital use. In 1962, following the disaster, New Jersey discovered that no state had ever put the assigned FM channels to use.

Working with the Federal authorities, state hospitals, and radio equipment manufacturers, the network in use today was devised. It operates on a frequency of 155.340 megacycles. Six hospitals serve as the base transmitters, giving full coverage of the state. Other hospitals are tied into the network as satellites

if they are within 40 miles of a base hospital. Base transmitters are rated at 60 watts of power, satellite transmitters at 30 watts.

About half of New Jersey's hospitals have joined the network. The equipment is used daily. This constant operation makes the members of the staff proficient in use of the equipment, and it also has proved a welcome augmentation of other methods of communication. Daily use of the radio network may include direct links between hospital and physician through mobile units, links between ambulance crews and the hospital, as well as communication between hospitals.

Hospitals now participating are:

CITY	HOSPITAL
Atlantic City	Atlantic City (Region)
Camden	West Jersey (Region)
	Cooper (Area)
	Our Lady Of Lourdes (Area)
East Orange	East Orange General (Area)
Elizabeth	Elizabeth General (Region)
	Alexian Brothers (Area)
Englewood	Englewood (Area)
Hackensack	Hackensack (Area)
Hasbrouck Heights	Hasbrouck Heights (Area)
Long Branch	Monmouth Medical Center (Area)
Montclair	St. Vincent's (Area)
Newark	United Hospitals (Area)
Newton	Newton Memorial (Region)
Plainfield	Muhlenberg (Area)
Point Pleasant	Point Pleasant (Area)
Rahway	Rahway (Area)
Salem	Salem Memorial (Area)
Somers Point	Shore Memorial (Area)
Somerville	Somerset (Area)
Sussex	Alexander Linn (Area)
Trenton	Mercer (Region)
	Helene Fuld (Area)
Vineland	Newcomb (Region)

Pediatric Fellowships Available

Applications for two-year Wyeth Pediatric Fellowships are available now for residencies commencing July 1, 1968. Sponsored by the Wyeth Fund for Postgraduate Medical Education, each fellowship provides $4,800 over two years toward the advanced training required for board certification in pediatrics. Wyeth's monthly payments, made directly to recipients, are in addition to the usual stipends paid to residents by the institutions in which they train.

Eligible to apply are interns, physicians who have completed an internship, research Fellows, or physicians completing their tour of duty with the Armed Services or the U.S. Public Health Service. Applicants must be citizens of the United States or Canada. Those who have already started a pediatric residency are not eligible. In the first nine years of this Fellowship program, 176 physicians have received its assistance toward their advanced training.

Each Fellow may choose the hospital in which he will train provided that it is accredited by the American Board of Pediatrics, the American Academy of Pediatrics, and the American Medical Association.

A voluntary committee of distinguished pediatricians supervises the program. In selecting the Fellows, this committee considers the following factors: character, academic achievement, performance of duties, and need for financial assistance. Wyeth plays no part in the selection of recipients.

If you know of any young doctor interested in pediatric training, write to Dr. Philip S. Barda, 120 Erdenheim Road, Philadelphia, Pennsylvania 19118, and ask for a Wyeth Pediatric Fellowship application form. Deadline is December 1, 1967.

Warning On STP

Dr. Roscoe P. Kandle, our State Commissioner of Health, needs information about any one using STP in New Jersey. The Federal Food and Drug Administration tells us that STP is claimed to be a hallucinogen. It has been found in tablets obtained from different parts of the country. The STP chemical substance is a still untested drug which could have harmful effects in man. Currently there is no toxicologic, pharmacologic, or therapeutic information on this substance available. Several persons who allegedly used STP have certainly suffered severe reactions.

ANNOUNCEMENTS

Lecture In Spectacle Optics

Under the auspices of the Academy of Medicine of New Jersey, lectures in Spectacle Optics will be given by Drs. Donald and Gerald Fonda on five Tuesday evenings — September 12, September 19, September 26, October 3, and October 10. The lectures will be held in Classroom A at the Saint Barnabas Medical Center, Livingston, New Jersey, from 8 until 9 p.m. on each of these evenings.

One Day Seminars In Brooklyn

Columbia University is repeating its popular Sunday Seminars starting on October 8. This year they will be held at Brookdale Hospital which is at Rockaway Parkway and Linden Boulevard. Here is the schedule:

October 8, 1967: Myocardial Infarction
November 12, 1967: Gastro-intestinal Hemorrhage
November 19, 1967: Controversies in Internal Medicine
December 16, 1967: Anemias
January 21, 1968: Renal Salt and Water Transport
February 18, 1968: Bronchogenic Carcinoma
March 17, 1968: Diabetes

For any one seminar, the registration fee is $35. For further information and application forms, write to Melvin D. Yahr, M.D., College of Physicians and Surgeons, 630 West 168th Street, New York, New York 10032

Electrocardiography Course In Camden

Our Lady of Loudres Hospital of Camden announces the second annual postgraduate course in electrocardiography. This will be given on ten consecutive Wednesday afternoons starting October 11, 1967, and is under the direction of Joseph M. Stein, M.D., William A. Halbeisen, M.D., and Thomas M. Kain, Jr., M.D. The course is designed to teach and encourage students in practical electrocardiography. Each student will participate fully in these exercises.

Approval for thirty hours credit has been granted by the American Academy of General Practice and the course is supported, in part, by grants from: Merck, Sharp and Dohme Post-graduate Education Fund; Smith, Kline and French Laboratories; and Parke, Davis and Company.

Applications for enrollment should be directed to: Frederick W. Floyd, Jr., M.D., Director of Medical Education, Our Lady of Lourdes Hospital, 1600 Haddon Avenue, Camden 08103.

Electrocardiography For The GP

Columbus Hospital will begin its 6th annual course in simplified electrocardiography for the family physician on Wednesday, October 11, 1967. The program includes 30 two-hour sessions extending to May 15, 1968. This course aims at giving the physician the basic knowledge needed for this subject. It provides maximum participation by students with individual instruction and exercises, both in the technical and diagnostic aspects of electrocardiography. Particular emphasis is placed on everyday problems such as myocardial infarction, arrhythmias, etc. Treatment (including intensive coronary care) is also stressed. For further information call area code 201, 485-3400 (Ext. 82), or write to Dr. Joseph Santangelo, 539 Mt. Prospect Avenue, Newark, New Jersey.

Nutrition And Metabolism Conference

The 12th Annual Conference on Nutrition and Metabolism is sponsored by the Philadelphia County Medical Society, the Philadelphia Pediatric Society, and the Council on Foods and Nutrition of the A.M.A. It will be held on Wednesday afternoon, October 18, 1967 at the home of the Philadelphia County Medical Society, 2100 Spring Garden Street.

Subjects to be covered include phenylketonuria, hypoglycemia, gout, and osteoporosis. This program is acceptable for American Academy of General Practice credit. For further information, communicate with Dr. Michael G. Wohl, Committee on Nutrition, Philadelphia County Medical Society, 2100 Spring Garden Street, Philadelphia, Pennsylvania 19130.

Genetics In Medical Practice

On Friday and Saturday, November 3 and 4, a symposium will be held in Philadelphia on genetics in medical practice. The fee for this is $35. For further details, write to John H. Killough, M.D., Jefferson Medical College, 1025 Walnut Street, Philadelphia 19107.

Course In Childhood Asthma

In Philadelphia an asthma symposium will be held on November 8 and 9. St. Christopher's Hospital, the Children's Heart Hospital, and Temple University have joined in developing this practical symposium. All aspects of childhood asthma will be covered. For enrollment or information, write to Dr. Leonard S. Girsh, Asthma Center, 3701 North Broad Street, Philadelphia, Pennsylvania 19140.

Nurses Meet In Morristown

The Fifteenth Annual Convention of the New Jersey League for Nursing will be held November 9 and 10, 1967, at the Governor Morris Hotel, Morristown. Theme of the convention is "Nursing: Choice, Cooperation, Change." The program will discuss the health needs, and preparation of personnel, as well as the coordination necessary for this community effort. Correlation of these efforts will be presented by participating speakers and panel members.

The New Jersey League for Nursing is primarily concerned with the promotion of better health and welfare of the people of the State, and in recruitment of professional and practical nurses. Members consist of nurses of all levels, plus others with a wide variety of abilities and interests, working together to bring better nursing to our communities.

For a detailed program, write to New Jersey League for Nursing at 605 Broad Street, Newark 07102.

Seminar On Disability Determinations

On Wednesday, November 29, 1967, starting at 9 a.m. (under the sponsorship of the New Jersey Rehabilitation Commission, Disability Determinations Service) there will be a one day seminar entitled, "The Doctor and the Disability Decision." The meeting will be held at the Rutger's Labor Education Center, Ryders Lane, New Brunswick.

Physicians will have an opportunity to learn disability evaluations, including their own role in these decisions. Special attention will be given to disabilities in the fields of orthopedics, cardio-pulmonary diseases, psychiatric disorders, special senses, and neurologic conditions. Doctors having special problems with disability determinations may submit questions in advance to Jarvis M. Smith, M.D., Medical Director, New Jersey Rehabilitation Commission, Labor and Industry Building, Trenton, 08625; these questions will be discussed at the meeting.

Study While You Sail

Reservations are now being accepted for the ever-popular postgraduate medical courses given on shipboard, developed by Albany Medical College. This year's group will float on the Raffaello, a luxurious vessel of the Italian Line. It leaves New York on January 17, and gets back there on the first day of February, 1968. It stops at ports in Venezuela, Curacao, the Virgin Islands, Puerto Rico, Jamica, Nassau, and Florida. While the main business will be absorption of newer knowledge in medicine (and AAGP gives 24 hours credit for it) there will be time for a little vacationing at these ports of call. For more information, write to the Department of Graduate Medicine, Albany Medical College, Albany, New York 12208.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hosital listed.

1967

September

12 **Bergen County Medical Society**

12 **The Academy of Medicine of New Jersey**
St. Barnabas Hospital, Livingston
Lecture in Spectacle Optics

14 **Burlington County Medical Society**
Scientific/Business

16 **The Academy of Medicine of New Jersey**
Newark Beth Israel Hospital
"Regional Anesthesia of Upper Extremities and Venous Perfusion"

19 **Passaic County Medical Society**

19 **The Academy of Medicine of New Jersey**
St. Barnabas Hospital, Livingston
Lecture in Spectacle Optics

20 **The Academy of Medicine of New Jersey**
Middlesex General Hospital, New Brunswick
"Recent Advances in Internal Medicine and Therapeutics"

21 **Somerset County Medical Society**

21 **Morris County Medical Society**
Warner-Lambert Research Institute, Morris Plains

26 **Cape May County Medical Society**

26 **The Academy of Medicine of New Jersey**
St. Barnabas Hospital, Livingston
Lecture in Spectacle Optics

27 **Monmouth County Medical Society**

27 **The Academy of Medicine of New Jersey**
Middlesex General Hospital, New Brunswick
"Recent Advances in Internal Medicine and Therapeutics"

27 **The Academy of Medicine of New Jersey**
Atlantic City Hospital
Congestive Heart Failure

October

3 **Hudson County Medical Society**

3 **The Academy of Medicine of New Jersey**
St. Barnabas Hospital, Livingston
Lecture in Spectacle Optics

4 **New Jersey Gastroenterology Society**
"Environmental Aspects of Gastrointestinal Disease"

4 **The Academy of Medicine of New Jersey**
Prudential Insurance Company, Newark
Annual Health Education Workshop

4 **The Academy of Medicine of New Jersey**
Middlesex General Hospital, New Brunswick
"Recent Advances in Internal Medicine and Therapeutics"

5 **The Academy of Medicine of New Jersey**
Somerset Hospital, Somerville
"Intensive Care of the Cardiac"

10 **The Academy of Medicine of New Jersey**
St. Barnabas Hospital, Livingston
Lecture in Spectacle Optics

10 **Bergen County Medical Society**

10 **Cumberland County Medical Society**

11 **Essex County Medical Society**
With Women's Auxiliary

11 **Ocean County Medical Society**

11 **The Academy of Medicine of New Jersey**
Middlesex General Hospital, New Brunswick
"Recent Advances in Internal Medicine and Therapeutics"

12 **Burlington County Medical Society**
Scientific/Business

17 **Warren County Medical Society**

18 **Middlesex County Medical Society**

18 **The Academy of Medicine of New Jersey**
Middlesex General Hospital, New Brunswick
"Recent Advances in Internal Medicine and Therapeutics"

18 **Passaic County Medical Society**

18 **New Jersey Obstetrical and Gynecological Society**
Holy Name Hospital, Teaneck

19 **Morris County Medical Society**

24 **The Academy of Medicine of New Jersey and Rutgers Medical School**
Rutgers, the State University, New Brunswick
Immunology Worshop

25 **The Academy of Medicine of New Jersey**
Middlesex General Hospital, New Brunswick
"Recent Advances in Internal Medicine and Therapeutics"

November

1 **The Academy of Medicine of New Jersey**
Middlesex General Hospital, New Brunswick
"Recent Advances in Internal Medicine and Therapeutics"

4 - 5 **New Jersey Society of Internal Medicine and College of Physicians**
Haddon Hall, Atlantic City

7 **Hudson County Medical Society**

8 **Ocean County Medical Society**

8 **The Academy of Medicine of New Jersey**
Atlantic City Hospital
"Intensive Care of the Cardiac"

8 **The Academy of Medicine of New Jersey**
Middlesex General Hospital, New Brunswick
"Recent Advances in Internal Medicine and Therapeutics"

9 **Burlington County Medical Society**
Scientific/Business

9 **Essex County Medical Society**

14 **Bergen County Medical Society**

15 **The Academy of Medicine of New Jersey**
Middlesex General Hospital, New Brunswick
"Recent Advances in Internal Medicine and Therapeutics"

15 **New Jersey State Dental Society**
Semi-Annual Session

15 **Middlesex County Medical Society**

15 **The Academy of Medicine of New Jersey**
Newark City Hospital
Workshop on Cytogenetics

16 **Morris County Medical Society**

21 **Passaic County Medical Society**

22 **Monmouth County Medical Society**

22 **The Academy of Medicine of New Jersey**
Middlesex General Hospital, New Brunswick
"Recent Advances in Internal Medicine and Therapeutics"

28 **Cape May County Medical Society**

29 **The Academy of Medicine of New Jersey**
Middlesex General Hospital, New Brunswick
"Recent Advances in Internal Medicine and Therapeutics"

December

5 **Hudson County Medical Society**

6 **The Academy of Medicine of New Jersey**
Robert Treat Hotel, Newark

"Antibiotic Induced Toxic and Hypersensitivity Reactions"

6 **The Academy of Medicine of New Jersey**
Middlesex General Hospital, New Brunswick
"Recent Advances in Internal Medicine and Therapeutics"

12 **Bergen County Medical Society**

12 **Cumberland County Medical Society**

13 **Ocean County Medical Society**

13 **The Academy of Medicine of New Jersey**
Middlesex General Hospital, New Brunswick
"Recent Advances in Internal Medicine and Therapeutics"

13 **The Academy of Medicine of New Jersey**
Cherry Hill Inn
Symposium on Trauma

14 **Burlington County Medical Society**
Scientific/Business

20 **The Academy of Medicine of New Jersey**
Middlesex General Hospital, New Brunswick
"Recent Advances in Internal Medicine and Therapeutics"

20 **Middlesex County Medical Society**

21 **Morris County Medical Society**

27 **The Academy of Medicine of New Jersey**
Middlesex General Hospital, New Brunswick
"Recent Advances in Internal Medicine and Therapeutics"

1968
January

3 **The Academy of Medicine of New Jersey**
Middlesex General Hospital, New Brunswick
"Recent Advances in Internal Medicine and Therapeutics"

10 **The Academy of Medicine of New Jersey**
Middlesex General Hospital, New Brunswick
"Recent Advances in Internal Medicine and Therapeutics"

11 **Essex County Medical Society**

17 **The Academy of Medicine of New Jersey**
Middlesex General Hospital, New Brunswick
"Recent Advances in Internal Medicine and Therapeutics"

18 **Morris County Medical Society**

24 **The Academy of Medicine of New**
31 **Jersey**
Middlesex General Hospital, New Brunswick
"Recent Advances in Internal Medicine and Therapeutics"

February

7 **The Academy of Medicine of New**
14 **Jersey**
Middlesex General Hospital, New Brunswick
"Recent Advances in Internal Medicine and Therapeutics"

15 **Morris County Medical Society**

21 **The Academy of Medicine of New Jersey**
Robert Treat Hotel, Newark
Pediatric Symposium

21 **The Academy of Medicine of New**
28 **Jersey**
Middlesex General Hospital, New Brunswick
"Recent Advances in Internal Medicine and Therapeutics"

March

6-9 **New Jersey Academy of General Practice**
Atlantic City

6 **The Academy of Medicine of New Jersey**
Middlesex General Hospital, New Brunswick
"Recent Advances in Internal Medicine and Therapeutics"

13 **The Academy of Medicine of New Jersey**
Mountainside Hospital, Montclair
Symposium on Supraventricular Arrhythmias

13 **The Academy of Medicine of New Jersey**
Middlesex General Hospital, New Brunswick
"Recent Advances in Internal Medicine and Therapeutics"

14 **Essex County Medical Society**

21 **The Academy of Medicine of New Jersey**
Middlesex General Hospital, New Brunswick
"Recent Advances in Internal Medicine and Therapeutics"

21 **Morris County Medical Society**

27 **The Academy of Medicine of New Jersey**
Middlesex General Hospital, New Brunswick
"Recent Advances in Internal Medicine and Therapeutics"

April

3, 10, 17 **The Academy of Medicine of New Jersey**
Middlesex General Hospital, New Brunswick
"Recent Advances in Internal Medicine and Therapeutics"

18 **Morris County Medical Society**

24 **The Academy of Medicine of New Jersey**
Middlesex General Hospital, New Brunswick
"Recent Advances in Internal Medicine and Therapeutics"

May

1 8 **The Academy of Medicine of New Jersey**
Middlesex General Hospital, New Brunswick
"Recent Advances in Internal Medicine and Therapeutics"

9 **Essex County Medical Society**

15 **The Academy of Medicine of New Jersey**
Middlesex General Hospital, New Brunswick
"Recent Advances in Internal Medicine and Therapeutics"

16 **Morris County Medical Society**

18-22 **Medical Society of New Jersey Annual Meeting**

22 29 **The Academy of Medicine of New Jersey**
Middlesex General Hospital, New Brunswick

Award For Rahway Doctor

The Malcolm C. Grow Award was presented this spring to Captain Clifford J. Buckley of Rahway, New Jersey, making him the "Flight Surgeon of the Year."

This award is presented annually to a surgeon or medical officer who is considered as having made the greatest contribution to the effectiveness of a flying organization during the preceding year.

Doctor Buckley received his M.D. from Hahnemann Medical College in 1962. He was assigned to the Air Force the following year, and to Aerospace Medicine in 1964.

Captain Buckley designed a medical jump-kit, which has since become standard pararescue equipment. He developed a plan to improve the efficiency and level of medical knowledge of pararescuemen. He flew missions all over the world in the interest of flight safety. He modified the science of helicopter hover to reduce the time of rescue missions. He has been prominent in launch and recovery deployments, and represents the Air Force at NASA conferences.

THE JOURNAL is glad to publish this item of evidence of another local boy who made good.

OBITUARIES

Dr. Benjamin W. Marino

On July 16, 1967, death came to Benjamin W. Marino, a well-known GP, industrial surgeon, and college physician in New Brunswick. Born in 1910, he received his M.D. at Georgetown in 1937, and interned at New York's Lincoln Hospital. He was medical inspector of New Brunswick public schools, an industrial physician for Squibb, and an associate director of student health at Rutgers. He was active in the affairs of the American Academy of General Practice and belonged to our component Middlesex County Medical Society.

Dr. Harold J. Megibow

One of New Jersey's civic leaders, Dr. Harold J. Megibow, died in Nevada on July 23, 1967. He was on a well-earned vacation from a busy general practice at the time of his passing —at the age of 55. Dr. Megibow had been president of the board of health in Ramsey, school physician for the high schools there, and a member of its planning board. He earned his M.D. at the Medical College of Virginia in 1937, and was affiliated with the Valley Hospital in Ridgewood. Dr. Megibow was in a pioneer airborne division—the 102nd —during World War II.

Dr. Philip Pollack

Dr. Philip Pollack, a well known Bergen County family doctor, died of a heart attack on July 23, 1967. Born in New York in 1905 he received his M.D. in 1935 at the University of Berne in Switzerland. He interned at St. Joseph's Hospital in Joliet, Illinois. Dr. Pollack was police surgeon for the Borough of River Edge and was active in committee work with the Bergen County Medical Society.

BOOK REVIEWS

Radiology in World War II. Colonel John Boyd Coates, Jr., M.D., USA, et al. Office of the Surgeon General, Department of the Army, Washington, D. C., 1966. 1132 Pages, 317 Illustrations, 8 Charts, 14 Maps. ($8.25)

Radiology in World War II starts with an excellent but brief history of the use of X-rays in military campaigns prior to 1941. The first military use of X-rays was in the Italian-Ethopian War of 1896, a short six months after Roentgen's discovery. Brief accounts of the use of X-ray during the Greco-Turkish War in 1897, the Sudan War of 1896-1898 under Lord Kitchner, the Boer War, and the Spanish American War are quite interesting.

The bulk of the book is a detailed account of the organization and practice of radiology during World War II. The solution to the problems of providing personnel, equipment, and adequate radiologic services in the remote corners of the earth, as well as the burdens placed upon army radiologists in the States are fully covered. Although the organizational information is interesting, among the surprising facts brought to light were the large number of research papers and case reports produced from the military experience. Actual radiographs are far too few although some innovations and interesting lesions are presented. The final chapters concern atomic bomb developments and are far too brief. This subject, however, has been well covered in several recent books.

Stylistically the book varies greatly with the thirty-one different contributors. In the best written parts there is an element of excitement at the approach and solutions of various problems. For the most part, the book is a compilation of chronologic events and facts and may be dull reading for the uninterested.

Radiology in World War II is an important book. The documentation of any era of medicine or medical specialty is useful from the standpoint of history and as a source for future development. The book does not have general appeal but is essential to the medical historian, of considerable interest to the military physician, and should provide a great element of nostalgia for all radiologists who served during the war.

James J. Stovin, M.D.

Introduction to Scientific Psychiatry. H. A. Storrow, M.D. New York, 1967, Appleton-Century-Crofts. Pp. 256. ($6.95)

Prior to the turn of the century, a psychiatric disability (like a delusion, or anxiety) was considered the disease. The fresh breeze from Vienna taught us to look for the emotional conflict behind the symptom. And it also suggested that you could not understand

the emotional conflict if you looked at it in cross-section. You had to see how it had developed, usually from childhood. Because of the concept here of "movement" (from childhood to the adult disability), this became known as a "dynamic" approach. This seized the imagination to the point where, as the decades of the twentieth century rolled on, the dynamic interpretation became the gospel — the only true psychiatry, the only method of eliminating the emotional conflict, and thus curing the disability.

By now, the dynamic model has been accepted for more than a half a century. By now, it has become the traditional, the conventional, perhaps the old-fashioned in psychiatry. And a new generation of psychiatrists is taking the helm and questioning these "dynamic ideas." Old-fashioned analysis, it is pointed out, has never met the test of achieving more favorable results than any other psychiatric treatment. By means of conventional "dynamic" criteria you can't predict, for instance, whether a certain family constellation will lead to alcoholism or delinquency or homosexuality. You can't repeat results, you can't predict them, and you can't count on two equally good psychiatrists making the same interpretation of the same data. Thus "dynamic" psychiatry is not a science, since it lacks predictability, reliability, objectivity, and repeatability, which are the touchstones of science.

This book makes a plea for a "conditioned reflex" concept of emotional illness. Neurotic and psychotic behavior are maladaptive, of course, but would not persist if they were not reinforced and can, one hopes, be controlled by making such behavior unrewarding. The text, written with considerable wit and sagacity, suggests various technics for extinguishing maladaptive behavior. Still unexplained is why neurotic behavior continues even when it is manifestly self-defeating, though, according to "scientific" theory, it should extinguish itself.

WILLIAM S. SCHRAM, M.D.

Labor: Clinical Evaluation and Management. Emanuel A. Friedman, M. D. New York, 1967, Appleton-Century-Crofts. Pp. 397 ($13.50)

Friedman's long awaited monograph is finally available and warrants a readily accessible place on the bookshelf of all who direct the management of labor or who have any interest in it.

In his easily readable style, Friedman devotes part one to normal labor with particular emphasis upon clinical cervimetry as a practical and reliable parameter in evaluation of labor. In part two there follows an analysis of dysfunctional labor, mainly evidenced in abnormalities of the cervimetric curve, but with reference also to arrest of descent of the presenting part. Parts three and four provide an exhaustive discussion of endogenous and exogenous factors influencing labor — one is left with the predetermination of the labor patterns once the legion of variables has been eliminated. While the treatment of the labor abnormalities is included under the appropriate headings, part five presents management in graphic terms readily usable in any clinical situation which might arise.

In conclusion, this book, with a wealth of supporting data and easily interpretable charts, represents a major contribution toward a better understanding of labor, not only for academicians, but particularly for anyone who is concerned with the sensible conduct of labor.

HERBERT F. NEUWALDER, M.D.

Hallux Valgus, Allied Deformities Of The Forefoot And Metatarsalgia. H. Kelikian, M.D. Philadelphia, 1965, W. B. Saunders Co. Pp. 495. ($19.50)

Doctor Kelikian's book is an unusual one. The first 450 pages present a detailed review of the many hundreds of articles written on hallux valgus and assorted deformities of the forefoot. This review covers concepts of anatomy, physiology, and deformity of the foot, as well as therapy, as these have evolved over hundreds of years of experience. The articles are carefully reviewed and presented in conjunction with illustrative photographs of excellent quality and, of even more value, beautiful line drawings. The photographs and comparable line drawings are frequently presented adjacent to one another so they are more clearly illustrative than they would be otherwise. Much of this material is of historic, rather than practical interest.

The last 50 pages detail carefully Kelikian's own viewpoints and recommendations in treatment of lesions of the forefoot. The same high quality of description and illustration is present in this area of the book. This volume, however will be of limited interest because of its topic. For the orthopedist primarily it will provide an encyclopedic review of the development of orthopedic concepts in physiology and treatment of the forefoot. Its bibliography allows the most careful student of the field easy access to the entire literature.

ROBERT GEORGE GREENE, M.D.

Laboratory Tests in Common Use. Solomon Garb, M.D. Fourth Edition. New York, 1966, Springer Publishing Company. Pp. 192 ($2.85)

This small paperback book "is written primarily for the nurse, the graduate as well as the student." It is also hoped by the author that it will prove useful to the medical secretary, medical student, and the physician. It describes in clear, easily read language a large number of clinical laboratory tests according to type of specimen used, e.g. blood, urine, cerebrospinal fluid, etc. Also included is a section on units of measurement used in laboratory medicine, and an excellent short chapter on care of needles and syringes and the technic of venipuncture. There are lists of tests used to measure disorders of the several organs and systems. The index is complete and well organized. The description under each test includes a succinct discussion of the importance and metabolism of the substance being tested, procedure for collecting the specimen, the basis of the laboratory method, possible interfering materials, and the normal range. The penultimate paragraphs are new to this edition and contain gems of information, useful not only to those for whom the book is intended, but also to the practicing pathologist. For example, under Bence-Jones protein, we are informed that the urine of patients who have taken out-dated tetracycline may contain this abnormal protein. For listing of information of this type under each test, I will keep the book on my ready reference shelf.

The book is strongly recommended for nurses, medical students, physicians (including pathologists), and others who might be concerned with the proper collection of laboratory specimens and the interpretation of results of same.

HUGH F. LUDDECKE, M.D.

Vascular Complications of Diabetes Mellitus. Edited by S. J. Kimura, M.D. and W. M. Caygill, M.D. St. Louis, 1967, Mosby. Pp. 276. Illustrated. ($19.75)

Reported here are the proceedings of a symposium at the University of California in December, 1965. The theme is microangiopathy of the retinal vessels complicating diabetes mellitus. Vascular changes in the kidney are also prominently discussed.

The Proctor Lecture, delivered by Norman Ashton, makes up the initial section and covers extensively the relationship between oxygen and the development of retinal vessels both *in vivo* and *in vitro*. The second part of the book discusses the scope of the problem of diabetic retinopathy, methods of fundus examination, and relationships between diabetes and glaucoma.

Vascular pathology both in the eye and kidney is the topic of the third and most extensive section. Included herein is material on fluorescein angiography of the retina and an excellent chapter on the natural course of diabetic retinopathy. This is of great help in evaluating the statistics as the various therapeutic modalities are discussed later in the book. Another part of the text focuses on medical treatment. Included here are the role of diet and insulin, hereditary factors, and immunologic considerations. In the last section, the anterior pituitary approach to therapy is discussed. The merits of pituitary irradiation, hypophyseal stalk section, pituitary cryosurgery, and trans-sphenoidal pituitary section are covered. Criteria for selection of cases are carefully considered.

Transcripts of panel discussions are interspersed throughout the text, and the written material is accompanied by many excellent retinal photographs and microphotographs. Comprehensive bibliographies are also presented with the papers.

This is a valuable addition to the already vast field of studies in diabetes mellitus. Not only ophthalmologists, but also internists, family physicians, pathologists, physiologists, and indeed all concerned with the problem will benefit from reading it.

WALTER T. RADOS, M.D.

New Drugs 1967 Edition. Chicago, 1967, American Medical Association. Pp. 590. ($3.50)

In spite of restrictions being imposed by the Food and Drug Administration, as well as by many states, new drugs keep coming out of the well-equipped laboratories of American pharmaceutical houses. And this is one of America's blessings, since it has made available to us some wonderful therapeutic tools that were undreamed of a decade or two ago. But it has led to an embarrassment of riches. How, in this abundant warehouse of medications, can the medical practitioner choose? He does not have the facilities to engage in private research. He can hardly accept the claim of every manufacturer's representative. He needs a road map through the network of modern drugs.

And here it is. This 1967 edition is a compilation of statements on various classes of drugs, plus monographs on single-entity items marketed in the United States during the decade just ended. Each of its 265 monographs gives information on the uses of the drug. Faithfully and candidly reported are adverse reactions, contraindications, precautions, dosages, routes of administration, and strengths of available preparations. The material is based on evaluations by the Council on Drugs and its consultants of all of the laboratory and clinical information (including unpublished data) available to them. Here is a concise, unbiased assessment of the newer terms within the perspective of the therapeutic application of all of the commonly used agents in each class of drugs. Since the monograph is included even if the Council's opinion is unfavorable, this book is in no sense a list of approved or accepted drugs.

The index lists drugs by both their nonproprietary (generic) and trade names and includes therapeutic entries. As a bonus, there is even a roster of Canadian trade name equivalents.

ULYSSES FRANK, M.D.

Great Ideas In The History Of Surgery. 2nd Edition. Leo H. Zimmerman, M.D. and Ilza Veith, Ph.D. New York, 1967, Dover Publications. Pp. 587. Illustrated. (Paperback—$3.00)

This paperback edition of a work originally published in 1961 is an interesting review of great ideas of surgery. It begins with the Edwin Smith Papyrus of ancient Egypt and ends with a discussion of the work of Ferdinand Sauerbruck who died in 1951. The final chapter mentions such recent greats as John B. Murphy, Alfred Blalock, Helen Taussig and Charles Bailey. The book should have wide appeal to physicians, surgeons, students, and even laymen. Anyone interested in history will find the book profitable reading. The authors give a brief biographic sketch of the outstanding personalities of the various periods and then offer quotations and translations from their writings. Typical of those included are Hippocrates, the Indian Sushruta, Lanfranc (who deplored the separation of physicians and surgeons), and Ambroise Paré who humbly stated, "I dressed him and God healed him." Several chapters are devoted to the giants of Great Britain including William Cheselden, Percivall Pott (of Pott's Fracture fame), the Bells of Scotland, and Lord Lister. Others of more recent vintage include Marion Sims of the U. S. A., Theodor Billrath, Theodor Kocher, and Edoardo Bassini.

One also learns from reading this book that some things really don't change much after all. In the Edward Smith Papyrus (written nearly 5,000 years ago) directions are given for the reduction of a dislocated mandible which describes the method we use today, including an alert that your thumbs don't get bitten. Albucasis in the 11th century describes the control of arterial bleeding by digital pressure. Quoting from William of Salicet in the 13th century, these words seem to have a modern ring: "a remuneration worthy of your labors, that is to say a very good fee, makes for the authority of the physician and increases the confidence which the patient has in him, even if the physician be of great ignorance." Malpractice suits are not new. Sir Astley Cooper in the early 1800's tells of a colleague who was sued and had to pay 400 pounds for failure to diagnose a dislocation of the shoulder.

The book is well written, easy to read, has an extensive bibliography and is well indexed. It left this reader with humility in the presence of his great predecessors and also with a good deal of pride to be a member of so great and ancient a profession. If as Shakespeare says, "What's Past is Prologue," is true, surgery will have a great future.

HUGH M. BABBITT, M.D.

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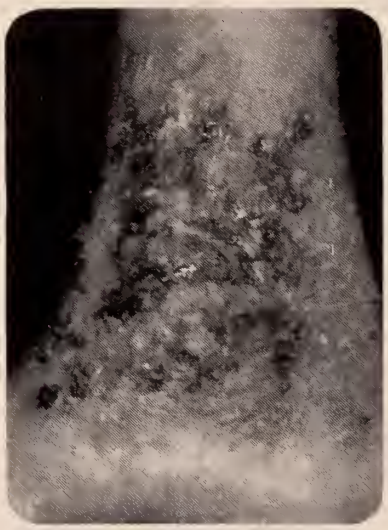
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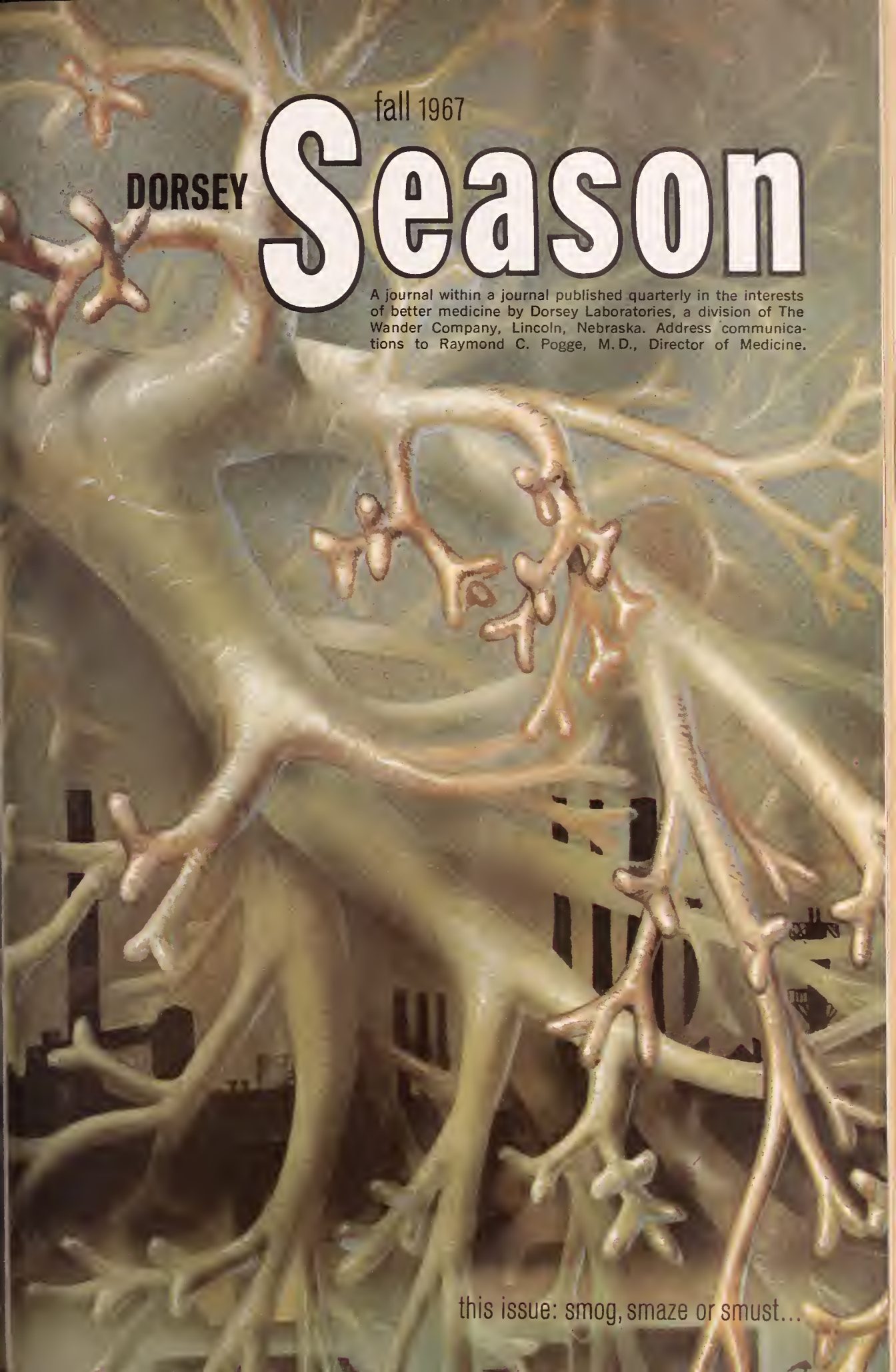
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this issue: smog, smaze or smust...

Smog, smaze or smust...effects of air pollution on upper respiratory tract

Nathan Flaxman, M.D., Diplomate, American Board of Internal Medicine, Chicago, Illinois

In Los Angeles it is *smog* (smoke and fog). In New York City *smaze* (smoke and haze). In El Paso *smust* (smoke and dust). The original factor was smoke plus such natural phenomena as fog, haze and dust, but air pollution has mushroomed from a smoke problem in our industrial cities into a major economic, esthetic and public health problem that affects practically every American locality and citizen.[1,2] Respiratory disease, of course, is by far the most costly effect of air pollution, for contaminated air can aggravate our illnesses, deplete our strength and shorten our life span.[1]

The greatest problem in dealing with solid wastes is that they are not quickly returned to dust. To aid the decomposing process, the great bulk of such waste is burned, polluting our air in the process.[3] Dr. Jack McKee of the California Institute of Technology[4] has calculated that in Los Angeles County, which has more than six million people, about three pounds of gaseous wastes per person per day (on a dry-weight basis) enter the atmosphere. This is twice as much as solid refuse disposal and six times as much as the contaminants in waste water. It is estimated that in New York City, 730 pounds of pollutants, a little over half the size of a compact two-door sedan of foreign make, is annually thrown into the air for each man, woman and child in the city.[5]

Air pollution is an evident factor, not only in the common cold and upper respiratory disease, but also in chronic bronchitis,[2] pulmonary emphysema,[6] bronchial asthma,[7] pneumonitis and lung cancer.[8] Its effect on the incidence of pulmonary tuberculosis is unproved,[9] although it is conceivable that the presence of various materials polluting the air migh do this. A siege of smog in Denver, the "mile higl city," in December 1965 was accompanied by resp ratory infection that doubled normal absentee rate in schools, factories and city government.[10]

While air pollution is only one factor, it has becom important in the causes of most of the afflictions o the respiratory tract. This has been shown not onl by the Denver occurrence, but also by detailed study of respiratory illness in a small group of 313 me



From October 1962 to May 1963 when there were 202 episodes involving the upper respiratory tract. The attack rate of illness was related in time to increased concentration of both smoke and sulphur dioxide in the atmosphere of the district in which the men lived.

Other factors often mentioned, include exposure to those who have colds, exposure to extreme changes of temperature, allergy and bacterial infection. However, when low individual resistance due to lack of rest, overwork, fatigue, improper or unbalanced diet, previous illness and emotional stress are included as causes, we enter the realm of somewhat obscure relationships. Much more emphasis can be placed on the role of polluted air.

The symptoms, signs and complications of involvement of the upper respiratory tract, especially the common cold, are the same regardless of the causative factor. Swelling of the lining of the nose, the scratchy dry throat, the discharge from the nose at first watery then thicker, discolored and more tenacious, the eyes tearing, and frequent sneezing are all part of the Number 1 human ailment. Concurrent or residual sinusitis when mucus is trapped there, middle ear involvement due to interference with drainage, laryngitis and bronchitis are complications of the common cold. The primary interference is with a most important function of the nose—the cleansing of foreign matter in the first line of "air defense" to prevent it from entering the breathing tract.

However, the diagnosis and subsequent decision on how to treat the patient so affected rests basically on the relief of symptoms that cause him the misery. The stuffed, runny nose, the clogged ears, and the harsh dry cough—all the symptoms that make common cold sufferers feel miserable and interfere with their sleep—can be alleviated with medications of the oral nasal decongestant/antihistamine combination type. The burning sensation in the throat, soreness of the chest and even chest pain can also be relieved by such medication. Rest in bed if there is fever (but confined to home at least), liberal fluids, uniformly warm surroundings and adequate humidity in the room, are all helpful adjuncts to the medication. Most common cold sufferers recover rapidly and are symptom-free in four to ten days.

Further treatment, altered by the fact that the affliction hangs on for more than the usual duration of the common cold, requires consideration of allergy, which is most frequently the prolonging factor. But air pollution itself may often be the culprit.

(Concluded on following page)

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At the Third National Conference on Air Pollution held recently, it was emphasized that this subject had received more attention in the past four years than in all previous history. Spicer,[11] an active participant at this conference, reiterated that it behooves the practicing physician to be aware of trends in respiratory disease and to accept a major role in community action relating to air pollution and respiratory health. By taking a positive stand physicians have been instrumental in the development of anti-pollution legislation. An outstanding example is Los Angeles where major steps have been taken by abolishing coal burning, and even banishing oil burning, seven months a year. Natural gas must be used instead and it must be used by industry when available. Backyard incinerators have been abolished in favor of landfill disposal, and building incineration ended except for a few expensive smokeless furnaces.[10] Concerted action can be taken against particular industrial nuisances. One company that disregarded complaints discovered its error when thousands of its credit cards were returned by irate customers who decided to patronize competing companies.[12]

Summary. Respiratory disease is the most important and most costly effect of air pollution, whether termed smog, smaze, or smust. Air pollution is an economic, esthetic and public health problem that affects practically every American locality and citizen. New sources of air pollution are invisible and odorless, but the harmful gases and liquid droplets are there. Triggered by sunlight, some of these undergo mid-air chemical changes and the results are even more irritating to the upper respiratory tract. The symptoms, signs and complications, especially of the upper respiratory tract, can be readily aborted by modern medication but may be unduly prolonged by polluted air. In steps taken to prevent this, the practicing physician can take a major role.

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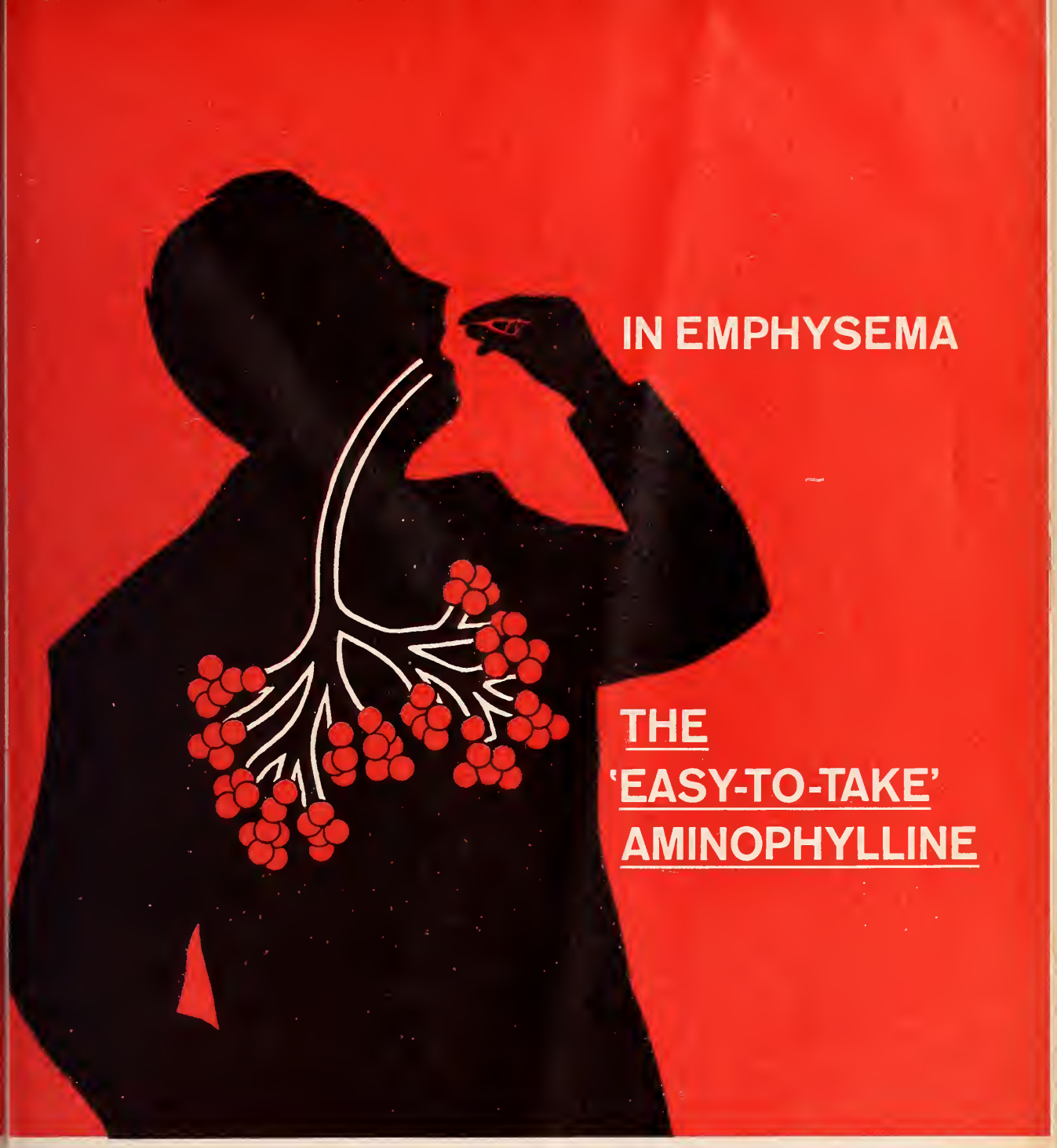
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The rauwolfia component of Enduronyl is deserpidine (Harmonyl®), a purified crystalline alkaloid supplied only by Abbott. It augments Enduron with its own antihypertensive and tranquilizing action.

Thus the combined clinical effect of these two therapeutic building blocks in Enduronyl is greater than can ordinarily be achieved with either alone.

To add flexibility, Enduronyl comes in two strengths: regular and Forte. Both provide 5 mg. of Enduron. The variation is where most helpful: in the deserpidine. The tablets are scored, and give a surprisingly wide and economical choice of once-a-day doses (see below).

Choose Enduronyl for your patients in the broad range of mild to moderate hypertension. Patient acceptance is excellent!



Once a day, every day

ENDURONYL®

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.25 MG.

ENDURONYL FORTE

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.5 MG.

	Minimum	Usual	Intermediate	Maximum
DAILY DOSAGE RANGE	2.5 mg. methyclothiazide 0.125 mg. deserpidine	5 mg. methyclothiazide 0.25 mg. deserpidine	7.5 mg. methyclothiazide 0.375 mg. deserpidine	10 mg. methyclothiazide 0.5 mg. deserpidine
DAILY DOSAGE RANGE	2.5 mg. methyclothiazide 0.25 mg. deserpidine	5 mg. methyclothiazide 0.5 mg. deserpidine	7.5 mg. methyclothiazide 0.75 mg. deserpidine	10 mg. methyclothiazide 1 mg. deserpidine

See Brief Summary on final page of advertisement.

707075-R

Eutonyl affords a different kind of basic therapy for moderate to severe cases

ABBOTT

Effect tied to reduced peripheral vascular resistance; no central depressant action

Eutonyl is a unique nonhydrazine agent. It is reported to act by reducing peripheral vascular resistance.[1,2]

In clinical trials, significant reductions in mean blood pressure were seen in 84% of patients studied—all were moderate to severe cases. Eutonyl lowers diastolic in proportion to systolic, and in about half of the cases studied, reductions in the sitting and recumbent positions were nearly as great as in the standing position.

Most important: There is no central depressant action. In fact, some patients reported an *increased* sense of well being.

Here, then, is a highly effective *basic treatment* for moderate to severe cases—and one that will not hamper your patient with lethargy or drowsiness while on treatment.

Once a day, every day

EUTONYL®
PARGYLINE HYDROCHLORIDE



DAILY DOSAGE RANGE	Minimum	Usual starting	Intermediate	Maximum
	10 mg. tablet	25 mg. tablet	50 mg. tablet or as needed	200 mg

1. Brest, A. N., et al., Cardiac and Renal Hemodynamic Response to Pargyline, Ann. N. Y. Acad. Sci., 107-1016, 1963.
2. Winsor, T., Pargyline Hydrochloride, Hypertension, Urinary Tryptamine, and Vascular Reflexes, Geriatrics, 19:598, Aug., 1964.

See *Brief Summary on final page of advertisement.*

Eutron adds thiazide for enhanced therapy with milder side effects

ABBOTT

Only a 7/4 mm. span between standing and recumbent pressures in clinical trials—reduced chance of orthostatic hypotension

The combining of Eutonyl and Enduron in Eutron permits a significantly greater antihypertensive effect than with either agent used alone. This in turn may allow therapeutic success with lesser dosage—and correspondingly milder side effects.

A significant finding in clinical trials was the drug's action in lowering blood pressure to *nearly equal levels in all body positions.* Total average spread between standing and recumbent readings (after treatment) was only 7/4 mm. Hg.

Thus, in your moderate to severe cases, Eutron affords a usually smooth course of therapy, often with reduced likelihood of orthostatic effects. (The usual precautions against rising suddenly, of course, will always apply.) And, because of the thiazide component, Eutron may be used in the presence of congestive heart failure.



Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 MG.
WITH METHYCLOTHIAZIDE 5 MG.

DAILY DOSAGE RANGE	Minimum	Usual starting	Intermediate	Maximum
	12.5 mg. pargyline hydrochloride and 2.5 mg. methyclothiazide	25 mg. pargyline hydrochloride and 5 mg. methyclothiazide	37.5 mg. pargyline hydrochloride and 7.5 mg. methyclothiazide	50 mg. pargyline hydrochloride and 10 mg. methyclothiazide

See Brief Summary on final page of advertisement.

TM—Trademark

707075-R

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Enduron is used to control edema and mild to moderate hypertension; also used with other drugs for hypertension. Enduronyl is used in mild to moderately severe hypertension; when used with Enduronyl, more potent agents can be given at reduced dosage to minimize undesirable side effects.

Contraindications: Neither Enduron nor Enduronyl should be used in severe renal disease (except nephrosis) or shutdown; in severe hepatic disease or impending hepatic coma; in patients sensitive to thiazides. Hepatic coma has been reported as a result of hypokalemia in patients receiving thiazides.

Enduronyl is contraindicated in patients with severe mental depression and suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity reactions in patients with a history of allergy or asthma. If added potassium intake is indicated, dietary supplementation is recommended. Enteric-coated potassium tablets should be reserved for cautious use only when adequate dietary supplementation is not practical because those tablets may induce serious or fatal small bowel lesions consisting of stenosis with or without ulceration. These small bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs.

Precautions: Use thiazides with caution in severe renal dysfunction, impaired hepatic function, or progressive liver disease. In surgical patients, thiazides may reduce the response to vasopressors and increase the response to tubocurarine. Use thiazides with caution in pregnancy (bone marrow depression, thrombocytopenia, or altered carbohydrate metabolism have been reported in certain newborn infants). Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. Antihypertensive response may be enhanced following sympathectomy.

Use Enduronyl with caution in patients with a history of peptic ulcer, as rauwolfias may increase gastric secretion. Discontinue at the first sign of mental depression. Rauwolfia alkaloids may increase hypotensive effects of surgery or anesthesia, and should be discontinued two weeks prior. They also lower the convulsive threshold and shorten seizure latency. In epilepsy, dosage adjustment of anticonvulsant medication may be necessary. Alcohol, barbiturates, or narcotics may potentiate action of deserpidine.

Adverse Reactions: During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). All patients should be observed for signs of hyponatremia ("low-salt" syndrome). Reported thiazide reactions include: anorexia, nausea, vomiting, diarrhea, headache, skin rash, dizziness, paresthesia, weakness, photosensitivity, jaundice, and pancreatitis.

Reported rauwolfia reactions include: nasal stuffiness, nausea, weight gain, diarrhea, aggravation of peptic ulcer, epistaxis, skin eruption, and reduction of libido and potency. Excessive drowsiness, fatigue, weakness, and nightmares may signal early signs of mental depression.

EUTONYL® | EUTRON™

PARGYLINE HYDROCHLORIDE

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications: For treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. Not recommended for patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone. It is desirable to establish the dosage of Eutron by administering component drugs separately.

TM-Trademark.

Contraindications: Pheochromocytoma, advanced renal disease, increasing renal dysfunction, paranoid schizophrenia and hyperthyroidism. Hepatic coma has been reported as consequence of hypokalemia with thiazide therapy. Until further experience is gained not recommended for patients with malignant hypertension, children under 12, or pregnant patients.

Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. 2 week interval should separate therapy and use of these agents.

Methyclothiazide is contraindicated in patients with known sensitivity to thiazides.

Warnings: Pargyline hydrochloride is a monoamine oxidase inhibitor. Warn patients against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When indicated, alcohol, narcotics (meperidine should be avoided), antihistamines, barbiturates, chloral hydrate, and other hypnotics, sedatives, tranquilizers, or caffeine, may be used cautiously in reduced dosage. In emergency surgery ¼ to ⅓ the usual dose of narcotics, analgesics, and other premedications should be used avoiding parenteral administration where possible. Carefully adjust dose of anesthetics to response of patient. Withdraw pargyline two weeks before elective surgery.

Warn patients about the possibility of postural hypotension. Those with angina or coronary artery disease should not increase physical activity with an improvement in well being. Pargyline may lower blood sugar.

Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions consisting of stenosis with or without ulceration. These small-bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs. These products contain no added potassium salts and if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical. In patients with a history of allergy or asthma the possibility of sensitivity reactions should be considered.

Precautions: Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields and fundi. Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. In surgical patients thiazides may reduce response to vasopressors and increase response to tubocurarine.

Adverse Reactions: Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extrapyramidal symptoms have been reported in a few patients with reduced cardiac reserve.

During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). Observe all patients for signs of hyponatremia ("low salt" syndrome).

Reported thiazide reactions also include anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, and pancreatitis. Nocturia has been observed with the combination.

709075R

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MEDICAL-SURGICAL PLAN OF NEW JERSEY

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Tissue's healing nicely. Yet anxiety slows his steps toward recovery.

By helping overcome anxiety and tension which can thwart the convalescent's progress, EQUANIL (meprobamate) often may play an important role in medical and surgical aftercare.

Cautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use may result in dependence or habituation in susceptible persons—as ex-addicts, alcoholics, severe psychoneurotics. After prolonged high dosage, drug should be withdrawn gradually to avoid possibly severe withdrawal reactions including epileptiform seizures. Side effects include drowsiness and, rarely, allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute non-thrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. If an allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Warn patients of possible reduced alcohol tolerance. Should drowsiness, ataxia, or visual disturbances occur, dose should be reduced. If symptoms persist, patients should not operate vehicles or dangerous machinery. A few cases of leucopenia, usually transient, have been reported following prolonged dosage. Other blood dyscrasias—aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia—have occurred rarely, almost always in the presence of known toxic agents. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. Prescribe very cautiously for patients with suicidal tendencies. Suicidal attempts should be treated with immediate gastric lavage and appropriate supportive therapy.

Contraindications: History of sensitivity to meprobamate.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

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Insurance that only covers claims based on the rendering of, or failure to render, professional services, or arising out of malpractice error or mistake in rendering professional services, is no longer adequate.

Our policy, approved and recommended by The Medical Society of New Jersey is broad enough to cover:

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(3) punitive damages for libel or slander.

This program, which was designed with The Medical Society of New Jersey and its legal counsel, and operated by a cooperative Loss Control Program, offers this broad protection, security and continuity of coverage.

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reliability of Dulcolax ms from its unique mode of ion. The drug works ectly on nerve endings in colonic mucosa, producing mal peristalsis throughout large intestine. It does rely on systemic absorption its effect.

s reliable action provides mpt relief of constipation. lso makes Dulcolax particulary useful for prepping the bowel for special procedures. In short, it makes Dulcolax ideal for your office practice.



Dulcolax acts so surely that the time of evacuation can often be closely predicted. Dulcolax tablets taken at night almost invariably result in a bowel movement soon after waking the following morning. Dulcolax suppositories generally work in 15 to 20 minutes, almost always within the hour.

l Dosage Information: *Adults:* When an ordinary laxative effect red, 1 to 3 tablets or 1 suppository usually suffices. Tablets e swallowed whole, not chewed or crushed, and should not be within one hour of antacids or milk. *Children:* 1 or 2 tablets, ding on age and severity of condition. Tablets must not be given ild too young to swallow them whole. For infants and children 2 years of age, half a suppository is usually effective. Above this whole suppository is usually advisable. Side Effects: As with any e, abdominal cramps are occasionally noted, particularly in severely constipated persons. High dosage may result in loose, unformed stools. Contraindication: Contraindicated only in acute surgical abdomen. Availability: Tablets (5 mg.) and suppositories (10 mg.). By prescription or recommendation.

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Geigy Pharmaceuticals
Division of Geigy Chemical Corporation, Ardsley, N.Y.

Geigy

You may be prescribing Hygroton®, chlorthalidone

You usually prescribe one tablet daily, but every once in a while you like to cut the dosage. So instead of giving the 100 mg. tablet every other day or breaking it in half, why not prescribe the new half-strength tablet every day?

See next page for a brief precautionary statement.

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New Hygroton 50 mg.

For a clinical supply, please mail us this coupon with one of your prescription blanks.

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DEPT. 7

Broad scope diuretic

Hygroton is indicated in certain conditions where the newer nonthiazide diuretics are not recommended, e.g. hypertension, edema of pregnancy, premenstrual edema, edema in obesity states, steroid edema.

However, the newer diuretics are probably superior to Hygroton in acute pulmonary edema and the nephrotic syndrome or any condition where the glomerular filtration rate is significantly low.

Hygroto
chlorthalidone

Geigy

Indications

Hypertension

Such as hypertension with or without congestive failure, where Hygroton can be used alone or in conjunction with other agents

(*Precaution:* Antihypertensive therapy with Hygroton should always be initiated cautiously in post-sympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol may potentiate hypotension.)

Edema

Such as edema associated with:
congestive heart failure
or renal disease
(*Precaution:* Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises.)
or hepatic cirrhosis
(Hypoproteinemia, if present, must be corrected concomitantly. *Precaution:* Take special care: discontinue if liver dysfunction is aggravated, since hepatic coma may be precipitated.)
or steroid administration
or obesity
or the premenstrual syndrome
or pregnancy, including toxemia
(*Warning:* Use with caution in pregnant patients, since the drug may cross the placental barrier and adverse reactions which may occur in the adult, e.g. thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc., are potential problems in the newborn.)

Contraindications

Severe Renal or Hepatic Disease and Demonstrated Hypersensitivity

Other general warnings, precautions and adverse reactions

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Precautions: Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Hygroton should be discontinued and potassium supplements given, provided the patient does not h marked oliguria.

Take special care in severe isc heart disease and in patients re corticosteroids, ACTH, or digit Salt restriction is not recomme

Adverse reactions: Nausea, ga irritation, vomiting, anorexia, c pation and cramping, dizziness ness, restlessness, hyperglyce hyperuricemia, headache, mus cramps, orthostatic hypotensio aplastic anemia, leukopenia, th cytopenia, agranulocytosis, dy impotence, transient myopia, sl rashes, urticaria, purpura, necr angiitis, acute gout, and pancre when epigastric pain or unexpl G.I. symptoms develop after pro administration. Other reactions reported with this class of com include: jaundice, xanthopsia, paresthesia, and photosensitiz

Average Dosage: 50-100 mg. wi breakfast daily.

Availability: White, single-score tablets of 100 mg. and aqua tabl 50 mg. in bottles of 100 and 100

Please see full Prescribing Info

Geigy Pharmaceuticals
Division of Geigy Chemical Corp
Ardsley, New York 10502

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Many patients, with or without a functional illness, show symptom
an aging metabolism: disinterest... lassitude... vague aches and pa

Mediatric® can help them lead a more active, useful



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s may indicate an underlying disorder that may
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That's why so many patients just like these are
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visit.

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in 100 patients to relieve some of the symptoms
d by degenerative changes of aging...." This
py resulted in improvement of 75 per cent of the
nts.

eill, A. J.: Clin. Med. *8*:518 (Mar.) 1961.

The estrogen component is PREMARIN® (conjugated estrogens—equine), the orally active, natural estrogen most widely prescribed for its physiologic and metabolic benefits. The combination of estrogen and *methyltestosterone* can help maintain an anabolic balance to forestall premature estrogen-related degenerative changes.

MEDIATRIC also supplies a small amount of *methamphetamine* to provide a gentle mood uplift; and nutritional supplements specially selected to meet the needs of the aging.

MEDIATRIC helps keep the older patients alert and active; helps relieve general malaise, easy fatigability, vague pains in the bones and joints, and lack of interest so often associated with declining gonadal hormone secretion.

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ate, due to methyltestosterone
onent.

ING: Some patients with pernicious
ia may not respond to treatment
he Tablets or Capsules, nor is ces-
of response predictable. Periodic
inations and laboratory studies of
cious anemia patients are essential
ecommended.

FFECTS: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.

SUGGESTED DOSAGES: **Male and female:** 1 Tablet or Capsule, or 3 teaspoonfuls Liquid, daily or as required.

In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

SUPPLIED: No. 752 – MEDIATRIC Tablets, in bottles of 100 and 1,000.

No. 252 – MEDIATRIC Capsules, in bottles of 30, 100, and 1,000.

No. 910 – MEDIATRIC Liquid, in bottles of 16 fluidounces and 1 gallon.

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	Each MEDIATRIC **TABLET or CAPSULE** contains:	Each 15 cc. (3 teaspoonfuls) of MEDIATRIC **LIQUID** contains:
Conjugated estrogens—equine (PREMARIN®)	0.25 mg.	0.25 mg.
Methyltestosterone	2.5 mg.	2.5 mg.
Methamphetamine HCl	1.0 mg.	1.0 mg.
Cyanocobalamin	2.5 mcg.	1.5 mcg.
Intrinsic factor concentrate	8.0 mg.	–
Thiamine HCl	–	5.0 mg.
Thiamine mononitrate	10.0 mg.	–
Riboflavin	5.0 mg.	–
Niacinamide	50.0 mg.	–
Pyridoxine HCl	3.0 mg.	–
Calcium pantothenate	20.0 mg.	–
Ferrous sulfate exsiccated	30.0 mg.	–
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Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.[3] Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.

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Prescribing Information: Composition: Each white, beveled, compressed tablet contains: Quinine Sulfate 260 mg. and Aminaphylline 195 mg. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions:** Aminaphylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchanism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

References: 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rawls, W., et al.: Med. Times, 87:818, 1959.

6/67 Q-706A

even in ulcerative colitis...

characterized by:
—diarrhea, cramps, tenesmus
—bloody, mucoid, purulent stools



LOMOTIL® tablets/liquid

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride 2.5 mg.
(Warning: May be habit forming)
atropine sulfate 0.025 mg.

controls diarrhea

In six published studies[1-6] detailed results are given on the use of Lomotil in 111 patients with chronic ulcerative colitis. They show that Lomotil gave satisfactory to "excellent" control of diarrhea in more than two-thirds of these patients. As the disorder advances and destroys bowel musculature, the motility-lowering action of Lomotil, understandably, has less effect.

The successful use of Lomotil in a disorder as exceedingly difficult to treat as moderate ulcerative colitis emphasizes again its unsurpassed antidiarrheal effectiveness in these more common conditions:

- **Gastroenteritis**
- **Acute infections**
- **Spastic colon**
- **Drug induced diarrhea**
- **Functional hypermotility**

For correct therapeutic effect
Rx correct therapeutic dosage

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are:

Children: Total Daily Dosage

3-6 mo. . . ½ tsp.* t.i.d. (3 mg.)
6-12 mo. . ½ tsp. q.i.d. (4 mg.)
1-2 yr. . . . ½ tsp. 5 times daily (5 mg.)
2-5 yr. . . . 1 tsp. t.i.d. (6 mg.)
5-8 yr. . . . 1 tsp. q.i.d. (8 mg.)
8-12 yr. . . 1 tsp. 5 times daily (10 mg.)
Adults: 2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.

*Based on 4 cc. per teaspoonful.
Maintenance dosage may be as low as one-fourth the initial daily dosage.

Precautions: Lomotil is a federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and tachycardia. Lomotil should be used with caution in patients with impaired liver function or those taking addicting drugs or barbiturates.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of the extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

1. Barowsky, H., and Schwartz, S. A.: J.A.M.A. *180*:1058-1061 (June 23) 1962. 2. Cayer, D., and Sohmer, M. F.: N. Carolina Med. J. 22:600-604 (Dec.) 1961. 3. Hock, C. W.: J. Med. Ass. Georgia 50:485-488 (Oct.) 1961. 4. Van Derstappen, G., and Vandenbroucke, G.: Med. Klin. 56:962-964 (June 2) 1961. 5. Merlo, M., and Brown, C. H.: Amer. J. Gastroent. 34:625-630 (Dec.) 1960. 6. Weingarten, B.; Weiss, J., and Simon, M.: Amer. J. Gastroent. 35:628-633 (June) 1961.

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Lilly

(See next page for prescribing information.)

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Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have also been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Adverse Reactions: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have developed in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly, usually within forty-eight hours, if the drug is readministered to sensitive patients. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice a
be definitely related to use of the drug, laboratory fin
characterized by increased direct-reacting bilirubir
alkaline phosphatase levels, negative or weakly positiv
flocculation and thymol turbidity tests, elevated serur
oxalacetic transaminase levels, peripheral eosinophili
mal cholecystograms.

Individual idiosyncrasy seems evident since jaundi
been reported in other patients taking prolonged cou
medication. Patients with chronic infection have been
to 2 Gm. of the drug daily for periods of two to six m
patients with rheumatic fever have taken prophylact
0.5 Gm. daily for two years without difficulty. In on
144 patients who received the drug daily for two year
dice was noted. It was of interest that members of si
patients' families, who were not taking the drug, ha
of jaundice during the study period.

Transaminase and serum alkaline phosphatase l
determined in a group of fifty-four adults and childre
250 mg. of Ilosone daily for an average of sixteen
rheumatic fever prophylaxis. The results were comp
those of a similar group of forty-four patients who rec
icillin. There were no cases of jaundice in either group.
of SGPT and serum alkaline phosphatase levels during
of treatment was observed in one patient treated wi
and in two patients treated with penicillin. Seven oth
in the group receiving Ilosone and four others in the
group showed elevations in one of the tests at some ti
administration of the drugs.

Very satisfactory therapeutic results, without toxi
reported in 102 pediatric patients who received short-
day) courses of Ilosone in the treatment of streptoco
tions. Results of liver function tests in these pati
comparable to those in a similar control group who ha
penicillin.

Gastro-intestinal disturbances not associated with l
fects are observed in a small proportion of individuals
of a local stimulating effect of the medication on the a
tract; however, the normal intestinal gram-negative
flora is not appreciably altered by erythromycin drug

Although allergic manifestations are uncommon wi
of erythromycin, there have been occasional reports of
skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered o

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Suspension, Ilosone Drops, Ilosone Chewable Tablets.

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children twenty-five to fifty pounds, 125 mg. every
(Tablets Ilosone Chewable should be chewed or cr
swallowed with water.)

For adults and for children over fifty pounds, the us
of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be double

When larger doses are indicated, parenteral ery
therapy should be considered.

In the treatment of syphilis, the recommended total
20 to 30 Gm. given in divided doses for a period of ten
days. Close follow-up of the patient is necessary sinc
mycin drugs have not had adequate evaluation in all
syphilis. Examinations of spinal fluid are recommend
of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four
recommended. In the treatment of gonorrhea, patien
suspected lesion of syphilis should have a dark-field ex
before receiving antibiotics, and monthly serologic te
be made for a period of three months.

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References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc.,
2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother.,
3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc.,
239:198, 1960.

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clinical judgment indicates Butazolidin alka—go with it.

And watch the comeback.



cer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Purpuric rash has also been reported. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur. 6509-V(B)R2

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patient is senile or when other potent drugs are given
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Adverse Reactions: The most common are nausea, edema and drug rash. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ul-

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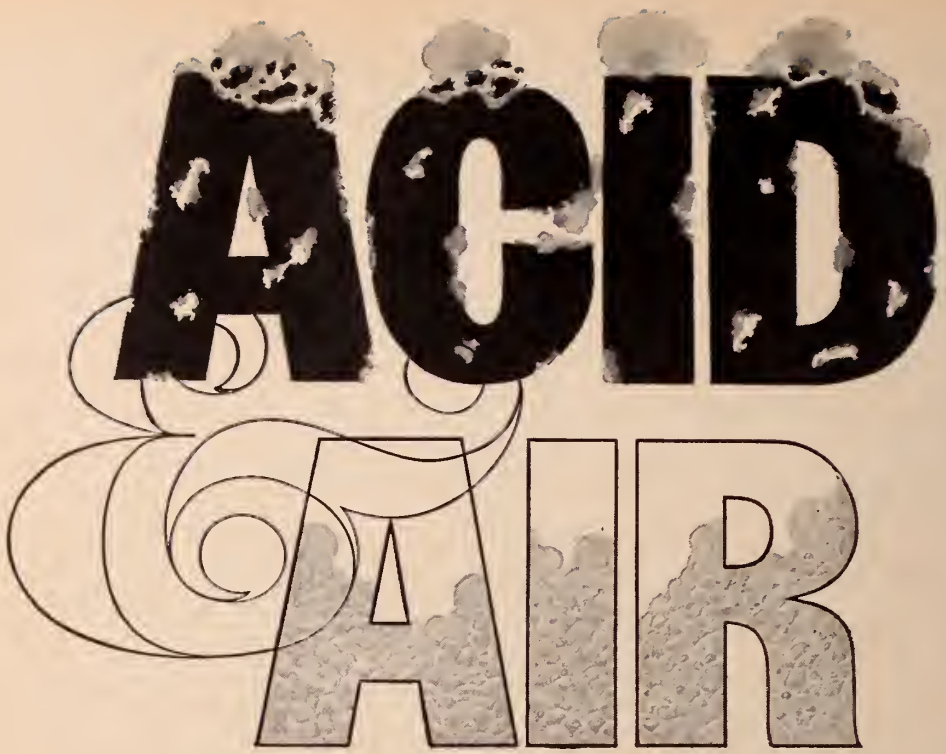
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DUAL PROBLEM IN PEPTIC ULCER

Relief of hyperacidity is still a primary goal in the treatment of peptic ulcer. And antacids are the most widely used means of achieving this relief. But antacids alone cannot influence the distention and bloating which so often add to ulcer distress.

THIS IS WHY MYLANTA® PROVIDES:

the two most widely used antacids—magnesium and aluminum hydroxides—to help secure rapid acid neutralization with little chance of laxation or constipation;

PLUS

the defoaming action of simethicone—to help relieve the painful gas symptoms which often accompany peptic ulcer.

Mylanta®

antacid therapy plus an added benefit

nonfatiguing flavor/smooth pleasant texture; both assure patient cooperation during long-term therapy.

Stuart Division of / ATLAS CHEMICAL INDUSTRIES, INC. / Pasadena, Calif.



Unique Nitrospan micro-dialysis process* adds an important dimension–TIME–to nitroglycerin therapy

Helps decrease frequency and severity of attacks; often increases exercise tolerance. Decreases need for sublingual nitroglycerin, increases patient confidence. Smooth, continuous release independent of gastrointestinal functions reduces headache and other side effects that might result from peak concentrations of tablet or intermittent-release preparations.

Indication and Dosage: For prophylactic use only in angina pectoris, 1 capsule every 12 hours. **Precautions:** For prophylaxis only, not for relief of acute anginal attacks. Tolerance to nitrites may develop on long-continued use. **Contraindications:** Idiosyncrasy to nitroglycerin, and early myocardial infarction. **Side Effects:** With use of nitrites, transient headache, postural hypotension, nausea and vomiting may occur. Overdoses may cause flushin dizziness, tachycardia, headache and syncope.

*The **micro-dialysis cell.** Nitrospan's timed-release mechanism is different from those usually employed in sustained-action capsules, which rely on unpredictable digestive processes. The nitroglycerin in Nitrospan capsules is contained within hundreds of dialysis cells of controlled permeability. The contents of each micro-dialysis cell are released by diffusion rather than disintegration, at a continuous rate independent of gastrointestinal action. Only the presence of fluid is required.



NEW from USV **NITROSPAN®** CAPSULES

brand of **nitroglycerin** 2.5 mg. in micro-dialysis cells

For a starter supply of NITROSPAN, write: USV PHARMACEUTICAL CORPORATION, 800 Second Avenue, New York, N.Y. 10017

WHO NEEDS IT?

With Medicare now in its second year, Title XIX around the corner, and powerful voices urging the substitution of panel practice for free-for-service in Government health programs, some doctors are asking, "Who needs Blue Shield?"

This prompted Dr. Frederick Margolis, president of The Medical Society of Michigan, to respond, "It seems clear to me that many of us are taking a short view of Blue Shield. Just whom would we rather have represent us in dealing with the government? Who else knows as much about prepaid programs, and as much about the detail of medical practice? Who else has the structure, professional talent, experience and the medical direction found in Blue Shield? I believe we need the capability that lies in Blue Shield, and we will need it more in the future. It would be well if we were all participating members who would then work from within to settle individual differences."

The same is true in New Jersey. The medical profession needs the strongest Blue Shield Plan possible—and only the profession can make it strong, through participation.

As the Plan this year salutes its pioneer Participating Physicians, in observance of our 25th Anniversary, we cordially invite those physicians who do not participate to become "pioneers" of the future, when the medical profession may need Blue Shield even more than in the past 25 years.

BLUE SHIELD®
MEDICAL-SURGICAL PLAN
OF NEW JERSEY
500 Broad Street, Newark



25TH YEAR OF SERVICE TO NEW JERSEY

A Building Block approach to treating hypertension

ABBOTT

With these three therapeutic building blocks you can create a once-a-day regimen to fit almost any degree of hypertension. See the following pages for details . . .



Consider starting your hypertensives on this basic thiazide

ABBOTT

A single daily dose of Enduron provides sodium excretion around the clock

Enduron is a true 24-hour single-dose thiazide. Its sodium excretion is not squeezed into an abrupt peak during the first several hours. It is well-sustained in a plateau-like effect—with little reduction for the first 12 hours, and decline thereafter only gradual.

Potassium loss, by contrast, is low. It reaches an early minor peak, then subsides rapidly. Moreover, since dosage is but once a day, there is but one daily peak of potassium loss. As with all thiazides, however, dietary potassium supplementation should also be considered, especially in long or intensive therapy.

Use Enduron as an ideal starting therapy in mild hypertension. Use it too, as a basic therapeutic building block with which other agents can be joined, for managing your more resistant hypertensives.

Once a day, every day

ENDURON®
METHYCLOTHIAZIDE



DAILY DOSAGE RANGE	Minimum	Usual	Intermediate	Maximum
	2.5 mg. tablet	5 mg. tablet	7.5 mg.	10 mg.

See Brief Summary on final page of advertisement.

To build added response, shift to Enduronyl

ABBOTT

The deserpidine component adds enhanced antihypertensive activity

The rauwolfia component of Enduronyl is deserpidine (Harmonyl®), a purified crystalline alkaloid supplied only by Abbott. It augments Enduron with its own antihypertensive and tranquilizing action.

Thus the combined clinical effect of these two therapeutic building blocks in Enduronyl is greater than can ordinarily be achieved with either alone.

To add flexibility, Enduronyl comes in two strengths: regular and Forte. Both provide 5 mg. of Enduron. The variation is where most helpful: in the deserpidine. The tablets are scored, and give a surprisingly wide and economical choice of once-a-day doses (see below).

Choose Enduronyl for your patients in the broad range of mild to moderate hypertension. Patient acceptance is excellent!



Once a day, every day

ENDURONYL®

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.25 MG.

ENDURONYL FORTE

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.5 MG.

	Minimum	Usual	Intermediate	Maximum
DAILY DOSAGE RANGE	2.5 mg. methyclothiazide 0.125 mg. deserpidine	5 mg. methyclothiazide 0.25 mg. deserpidine	7.5 mg. methyclothiazide 0.375 mg. deserpidine	10 mg. methyclothiazide 0.5 mg. deserpidine
DAILY DOSAGE RANGE	2.5 mg. methyclothiazide 0.25 mg. deserpidine	5 mg. methyclothiazide 0.5 mg. deserpidine	7.5 mg. methyclothiazide 0.75 mg. deserpidine	10 mg. methyclothiazide 1 mg. deserpidine

See Brief Summary on final page of advertisement.

707075-R

Eutonyl affords a different kind of basic therapy for moderate to severe cases

ABBOTT

Effect tied to reduced peripheral vascular resistance; no central depressant action

Eutonyl is a unique nonhydrazine agent. It is reported to act by reducing peripheral vascular resistance.[1,2]

In clinical trials, significant reductions in mean blood pressure were seen in 84% of patients studied—all were moderate to severe cases. Eutonyl lowers diastolic in proportion to systolic, and in about half of the cases studied, reductions in the sitting and recumbent positions were nearly as great as in the standing position.

Most important: There is no central depressant action. In fact, some patients reported an *increased* sense of well being.

Here, then, is a highly effective *basic treatment* for moderate to severe cases—and one that will not hamper your patient with lethargy or drowsiness while on treatment.

Once a day, every day

EUTONYL®
PARGYLINE HYDROCHLORIDE



DAILY DOSAGE RANGE	Minimum	Usual starting	Intermediate	Maximum
	10 mg. tablet	25 mg. tablet	50 mg. tablet or as needed	200 mg.

1. Brest, A. N., et al., Cardiac and Renal Hemodynamic Response to Pargyline, Ann. N. Y. Acad. Sci., 107-1016, 1963.
2. Winsor, T., Pargyline Hydrochloride, Hypertension, Urinary Tryptamine, and Vascular Reflexes, Geriatrics, 19:598, Aug., 1964.

See Brief Summary on final page of advertisement.

Eutron adds thiazide for enhanced therapy with milder side effects

ABBOTT

Only a 7/4 mm. span between standing and recumbent pressures in clinical trials—reduced chance of orthostatic hypotension

The combining of Eutonyl and Enduron in Eutron permits a significantly greater antihypertensive effect than with either agent used alone. This in turn may allow therapeutic success with lesser dosage—and correspondingly milder side effects.

A significant finding in clinical trials was the drug's action in lowering blood pressure to *nearly equal levels in all body positions*. Total average spread between standing and recumbent readings (after treatment) was only 7/4 mm. Hg.

Thus, in your moderate to severe cases, Eutron affords a usually smooth course of therapy, often with reduced likelihood of orthostatic effects. (The usual precautions against rising suddenly, of course, will always apply.) And, because of the thiazide component, Eutron may be used in the presence of congestive heart failure.



Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 MG.
WITH METHYCLOTHIAZIDE 5 MG.

DAILY DOSAGE RANGE	Minimum	Usual starting	Intermediate	Maximum
	12.5 mg. pargyline hydrochloride and 2.5 mg. methyclothiazide	25 mg. pargyline hydrochloride and 5 mg. methyclothiazide	37.5 mg. pargyline hydrochloride and 7.5 mg. methyclothiazide	50 mg. pargyline hydrochloride and 10 mg. methyclothiazide

See Brief Summary on final page of advertisement.

TM—Trademark

707075-R

ENDURON | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Enduron is used to control edema and mild to moderate hypertension; also used with other drugs for hypertension. Enduronyl is used in mild to moderately severe hypertension; when used with Enduronyl, more potent agents can be given at reduced dosage to minimize undesirable side effects.

Contraindications: Neither Enduron nor Enduronyl should be used in severe renal disease (except nephrosis) or shutdown; in severe hepatic disease or impending hepatic coma; in patients sensitive to thiazides. Hepatic coma has been reported as a result of hypokalemia in patients receiving thiazides.

Enduronyl is contraindicated in patients with severe mental depression and suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity reactions in patients with a history of allergy or asthma. If added potassium intake is indicated, dietary supplementation is recommended. Enteric-coated potassium tablets should be reserved for cautious use only when adequate dietary supplementation is not practical because those tablets may induce serious or fatal small bowel lesions consisting of stenosis with or without ulceration. These small bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs.

Precautions: Use thiazides with caution in severe renal dysfunction, impaired hepatic function, or progressive liver disease. In surgical patients, thiazides may reduce the response to vasopressors and increase the response to tubocurarine. Use thiazides with caution in pregnancy (bone marrow depression, thrombocytopenia, or altered carbohydrate metabolism have been reported in certain newborn infants). Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. Antihypertensive response may be enhanced following sympathectomy.

Use Enduronyl with caution in patients with a history of peptic ulcer, as rauwolfias may increase gastric secretion. Discontinue at the first sign of mental depression. Rauwolfia alkaloids may increase hypotensive effects of surgery or anesthesia, and should be discontinued two weeks prior. They also lower the convulsive threshold and shorten seizure latency. In epilepsy, dosage adjustment of anticonvulsant medication may be necessary. Alcohol, barbiturates, or narcotics may potentiate action of deserpidine.

Adverse Reactions: During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). All patients should be observed for signs of hyponatremia ("low-salt" syndrome). Reported thiazide reactions include: anorexia, nausea, vomiting, diarrhea, headache, skin rash, dizziness, paresthesia, weakness, photosensitivity, jaundice, and pancreatitis.

Reported rauwolfia reactions include: nasal stuffiness, nausea, weight gain, diarrhea, aggravation of peptic ulcer, epistaxis, skin eruption, and reduction of libido and potency. Excessive drowsiness, fatigue, weakness, and nightmares may signal early signs of mental depression.

EUTONYL® | EUTRON™

PARGYLINE HYDROCHLORIDE

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications: For treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. Not recommended for patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone. It is desirable to establish the dosage of Eutron by administering component drugs separately.

TM-Trademark.

Contraindications: Pheochromocytoma, advanced renal disease, increasing renal dysfunction, paranoid schizophrenia and hyperthyroidism. Hepatic coma has been reported as consequence of hypokalemia with thiazide therapy. Until further experience is gained not recommended for patients with malignant hypertension, children under 12, or pregnant patients.

Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. 2 week interval should separate therapy and use of these agents.

Methyclothiazide is contraindicated in patients with known sensitivity to thiazides.

Warnings: Pargyline hydrochloride is a monoamine oxidase inhibitor. Warn patients against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When indicated, alcohol, narcotics (meperidine should be avoided), antihistamines, barbiturates, chloral hydrate, and other hypnotics, sedatives, tranquilizers, or caffeine, may be used cautiously in reduced dosage. In emergency surgery ¼ to ⅓ the usual dose of narcotics, analgesics, and other premedications should be used avoiding parenteral administration where possible. Carefully adjust dose of anesthetics to response of patient. Withdraw pargyline two weeks before elective surgery.

Warn patients about the possibility of postural hypotension. Those with angina or coronary artery disease should not increase physical activity with an improvement in well being. Pargyline may lower blood sugar.

Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions consisting of stenosis with or without ulceration. These small-bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs. These products contain no added potassium salts and if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical. In patients with a history of allergy or asthma the possibility of sensitivity reactions should be considered.

Precautions: Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields and fundi. Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. In surgical patients thiazides may reduce response to vasopressors and increase response to tubocurarine.

Adverse Reactions: Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extrapyramidal symptoms have been reported in a few patients with reduced cardiac reserve.

During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). Observe all patients for signs of hyponatremia ("low salt" syndrome).

Reported thiazide reactions also include anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, and pancreatitis. Nocturia has been observed with the combination.

ABBOTT

709075R



New view of an oral contraceptive at work

Although suppression of ovulation remains the primary mode of action of oral contraceptives, newer knowledge indicates that products like Norinyl-1— a combination of both low-dosage progestogen and estrogen for the full treatment cycle—may provide multiple action that helps explain their unexcelled record of contraceptive effectiveness. This report explores the possible secondary protective mechanisms offered by combined hormonal administration.

Accumulating evidence has indicated that sparse, highly viscous cervical mucus has a possible adverse effect on the motility and survival of spermatozoa.

The estrogen-opposing progestational ingredient of Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.) changes the usual midcycle picture of a thin, watery cervical mucus. The result—a built-in barrier that appears to inhibit sperm from reaching the ovum should one be released. The inset in the adjoining photograph shows immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

See last page for contraindications, precautions, side effects and dosage.

How the estrogen-opposing action of Norinyl-1 creates cervical mucus that may be hostile to sperm penetration

Normally, estrogen activity during the fertile midcycle stimulates the production of a profuse and watery cervical mucus that permits maximum sperm motility and promotes penetration.

But what happens when Norinyl-1 is administered? Its potent progestogen, norethindrone, opposes estrogen stimulation of cervical mucus. Consequently, the amount of mucus decreases and its viscosity increases. This results in a sparse but thick mucus barrier that appears to diminish the vitality of the sperm and to impair its powers of penetration.

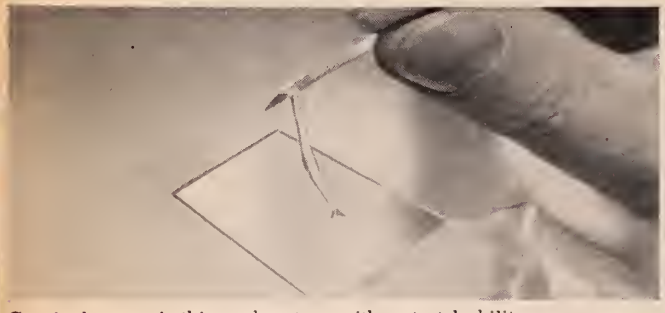
The role of viscous cervical mucus as a secondary action of Norinyl-1

In a report on 89 patients taking this medication,* cervical mucus obtained from cycle day 5 to cycle day 29 appeared scant and thick and exhibited little or no Spinnbarkeit.

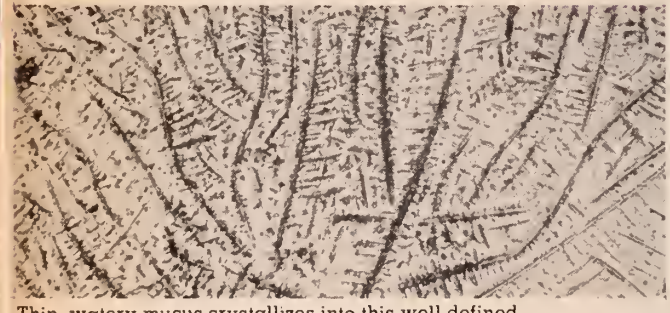
In the opinion of this investigator, the effect on cervical mucus may be sufficient to prevent conception.

*Cohen, M. R.: Symposium: Mechanisms of Action of Low Dosage Oral Contraceptive, Yale University Medical Center, New Haven, Conn., April 6, 196

Normal cervical mucus at midcycle in untreated patient is known to permit sperm motility... promote sperm penetration.



Cervical mucus is thin and watery with a stretchability (Spinnbarkeit) of 15 to 20 cm.



Thin, watery mucus crystallizes into this well-defined, fernlike pattern within a minute.

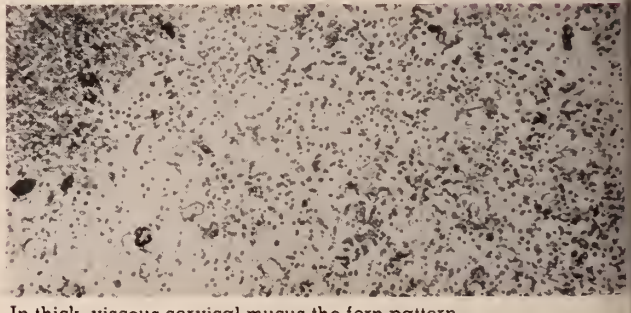


Spermatozoa appear healthy, are active and freemoving.

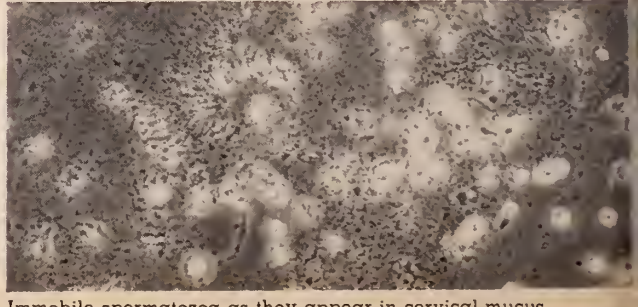
Viscous cervical mucus at midcycle produced by Norinyl-1 appears to impair sperm vitality... inhibit penetration.



Cervical mucus is scanty, thick and viscous. Spinnbarkeit is 1 cm. or less.



In thick, viscous cervical mucus the fern pattern is poorly defined or absent.

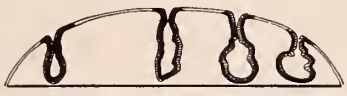


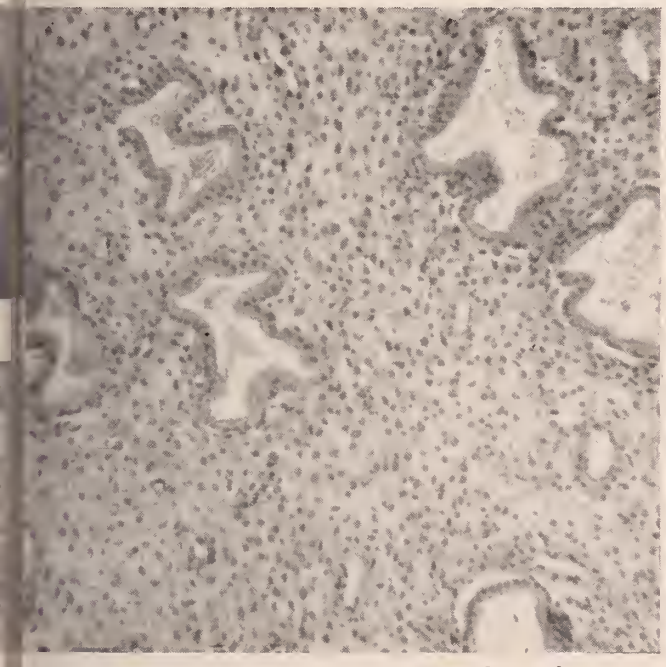
Immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

How Norinyl-1 alters normal endometrial responses—another possible protective mechanism

Let us suppose that an ovum is released—as occurs in an occasional, rare case—and somehow a sperm succeeds in penetrating the cervical mucus barrier. Should this come about, the additional action of Norinyl-1 may protect the patient from unwanted pregnancy. The theory is that progestogen intake makes endometrial tissue unreceptive to implantation.

Endometrium of untreated patient

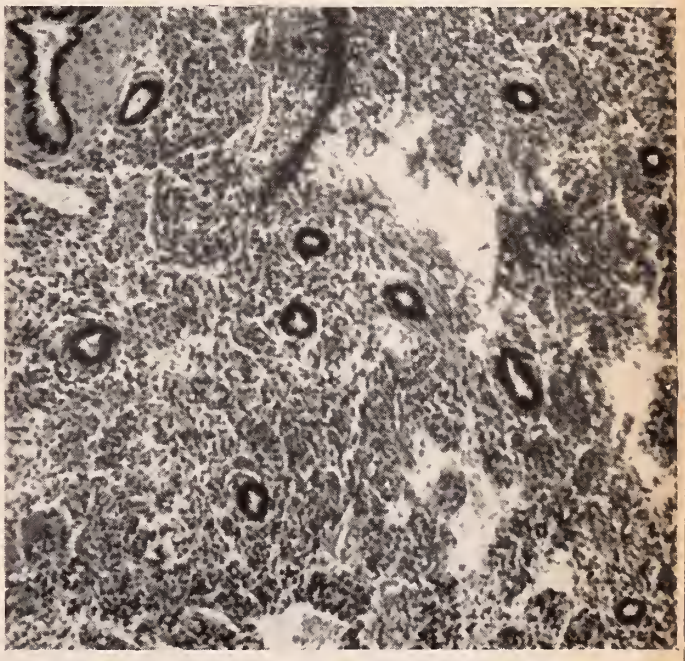




Normally, the endometrium progresses through proliferative phase stimulated by estrogen and a secretory phase stimulated by progesterone. During the secretory phase the endometrium is receptive to the fertilized ovum.

Endometrium produced by Norinyl-1





When Norinyl-1 is administered its progestogen component—norethindrone—accelerates the secretory phase and suppresses glandular and vascular development.

new Norinyl®-1
(norethindrone 1mg. & mestranol 0.05mg.) tablets

See last page for contraindications, precautions, side effects and dosage.

effective fertility control
on half the previous dosage

maintains ratio
of the established
norethindrone/mestranol
combination

lower cost

new Norinyl®

(norethindrone 1mg. & mestranol 0.05mg.) **tablets**

Reduction of oral contraceptive dosage to lowest effective levels has become a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now available in a new strength in which *both* norethindrone and mestranol are reduced 50 per cent. Studies show that Norinyl-1 achieves fertility control with only 0.5 mg. of combined progestogen and estrogen per tablet.

Norethindrone was first reported for use as a progestational agent in human beings in 1955. Norethindrone 2 mg. with mestranol 0.1 mg. as an oral contraceptive, is currently in use by over 2,000,000 women. Clinical experience now establishes that Norinyl-1 also amply meets the criteria of reliability and safety.*

*Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965.

PRESCRIBING INFORMATION

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of Norinyl-1 in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with Norinyl-1. Therefore, if such tests are abnormal in a patient taking Norinyl-1, it is recommended that they be repeated after the drug has been withdrawn for 2 months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibroids may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac, or renal dysfunction, require careful observation. 5. Although a cause and effect relationship has not been established, Norinyl-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, as in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged Norinyl-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Norinyl-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. A cause and effect relationship has not been demonstrated. 11. Because of the effects of estrogens on epiphyseal closure, Norinyl-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask the onset of the climacteric. 13. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma, breast changes (tenderness, enlargement and secretion), loss of scalp hair, change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, erythema multiforme, erythema nodosum, hemorrhagic eruption, migraine, rash (allergic), itching, rise in blood pressure in susceptible individuals, mental depression.

The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has not been established: thrombophlebitis, pulmonary embolism, neurooocular lesions.

The following laboratory results may be altered by the use of oral contraceptive increased bromsulphalein retention and hepatic function tests, coagulation tests crease in prothrombin, factors VII, VIII, IX X), thyroid function (increase in PBI and nol extractable protein-bound iodine and crease in T^3 values), metapyrone test, preg diol determination.

Other side effects reported to have occu in association with use of this drug are ness, hirsutism, pains in legs, back, chest abdomen, dysuria, drowsiness, vaginal charge, libido increased and decreased, tions, hypermenorrhea, hypomenorr increased appetite, G.U. infections, vari veins, abdominal fullness, acne, heade nervousness, allergies, blurred vision, pai eyes, and itching in eyes. *For complete clin data, see package insert.*

Dosage and Administration: 1. One table Norinyl-1 is administered orally for 20 c beginning on day 5 of the menstrual c (Count day 1 of the cycle as the first da menstrual bleeding.) Repeat this dosage sc ule for each cycle. 2. If no menstrual pe occurs after a cycle of treatment (20 tablets which patient adhered to the schedule, the tient must be instructed to resume taking Norinyl-1 tablets 7 days after the previous day course was completed. For example, if last pill of a previous cycle had been taker a Sunday, then a new cycle of treatment sho begin on the following Sunday. 3. In the p partum woman, it is recommended that first cycle of treatment should begin on da of the first menstrual cycle. However, Norin should not be administered during lactation.

Availability: Norinyl-1 (norethindrone 1 with mestranol 0.05 mg.)—Dispensers of 20 c 60 and bottles of 250 tablets.

norethindrone — an original steroid from

SYNTEX

LABORATORIES INC., PALO ALTO, CALIF.

Before prescribing, see complete prescribing information in SK&F literature or *PDR.* A brief precautionary statement follows.
Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal obstruction, or bladder neck obstruction.
Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.
Usage in Pregnancy: Use cautiously, especially in the first trimester. *Note:* The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.
Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible side effects of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported but no causal relationship has been established.



a stuffy nose is no laughing matter

Ornade® Trademark

Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate), 50 mg. of phenylpropanolamine hydrochloride, and 2.5 mg. of isopropamide, as the iodide.

Spansule® Capsules

brand of sustained release capsules

each one can give him all-day or all-night relief

SK&F Smith Kline & French Laboratories



when he just can't sleep

Tuinal

One-Half Sodium Amobarbital and
One-Half Sodium Secobarbital
supplied in ¾, 1½, and 3-grain Pulvules



'inal helps wakeful patients fall asleep fast, stay leep all night.

dications: Tuinal is indicated for prompt and moderely long-acting hypnosis. It is not suitable for conuous daytime sedation.

ontraindications: Barbiturates should not be adminisred to anyone with a history of porphyria, nor should ey be given in the presence of uncontrolled pain, beuse excitement may result.

arning: May be habit-forming.

ecautions: Tuinal should be used cautiously in paents with decreased liver function, since prolongation effect may occur.

dverse Reactions: Idiosyncrasy, such as excitement, ngover, or pain, may appear. Hypersensitivity reactions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.

Overdosage: C.N.S. depression. Symptoms—Depression of respiration and of superficial and deep reflexes, slight constriction of the pupils (in severe poisoning, dilation), decreased urine formation, lowered body temperature, coma. Treatment—Symptomatic and supportive (gastric lavage; intravenous fluids; maintenance of blood pressure, body temperature, and adequate respiration). Dialysis may speed removal of barbiturates from body fluids.



Dosage: 50-200 mg. (¾-3 grains) at bedtime.

[031767]

Additional information available to physicians upon request.
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Lilly



following infection

B and C vitamins are therapy: STRESSCAPS B and C vitamins in th
peutic amounts...help the body mobilize defenses during convalescence..
response to primary therapy. The patient with a severe infection, and m
others undergoing physiologic stress, may benefit from STRESSCAPS capsu



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FOR PROFESSIONAL
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Each capsule contains:	
Vitamin B_1 (as Thiamine Mononitrate)	10 m
Vitamin B_2 (Riboflavin)	10 m
Vitamin B_6 (Pyridoxine HCl)	2 m
Vitamin B_{12} Crystalline	4 mcg
Vitamin C (Ascorbic Acid)	300 m
Niacinamide	100 m
Calcium Pantothenate	20 m

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

626-6-

WEIGHT CONTROL calls for OBETROL®

Each OBETROL-10 tablet contains: Methamphetamine Saccharate; 2.5 mg. Methamphetamine Hydrochloride; 2.5 mg. Amphetamine Sulfate; 2.5 mg. Dextro-amphetamine Sulfate; 2.5 mg. (OBETROL-20 tablets contain twice this potency) Pat. #2748052.



This combination of amphetamines may be useful as an adjunct in the management of certain forms of obesity where an appetite depressant is indicated.

Contraindications: Hypertension, advanced arteriosclerosis, coronary artery disease, cardiac arrhythmias, peripheral vascular disease, states of undue restlessness, anxiety, excitement, agitated depression, hyperthyroidism, idiosyncrasy to amphetamine, concomitant administration of a monoamine oxidase inhibitor. **Precautions:** Use with caution in individuals with anorexia, insomnia, vasomotor instability, asthenia, psychopathic personality, a history of homicidal or suicidal tendencies, and individuals who are known to be hyperractive to sympathomimetic agents, or emotionally unstable individuals who are known to be susceptible to drug abuse. Certain monoamine oxidase inhibitors may potentiate the action of Obetrol. **Side Effects:** The most common side effects attended with the use of amphetamines include nervousness, excitability, euphoria, insomnia, dryness of mouth, nausea, vertigo, constipation, and headache. **Dosage and Administration:** Initial adult dose is one-half to one 'Obetrol-10' tablet daily, preferably one-half to one hour before meals. This may be gradually increased to one 'Obetrol-10' or 'Obetrol-20' tablet one to three times daily as indicated. **Supplied:** Tablets scored, in bottles of 100, 500, and 1000.

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OBETROL PHARMACEUTICALS
Div. of Rexar Pharmacal Corp., Brooklyn, N.Y. 11207

when bursitis hits a 280-lb. tackle, hit back with Butazolidin alka



Indications: Osteoarthritis, rheumatoid arthritis, rheumatoid spondylitis, psoriatic arthritis, acute gout, painful shoulder (peritendinitis, capsulitis, bursitis and acute arthritis of that joint), acute superficial thrombophlebitis.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, av those responsive to routine measures as well as contraindicate tients. Obtain a detailed history and a complete physical and labo examination, including a blood count. The patient should not e: recommended dosage, should be closely supervised and shou warned to discontinue the drug and report immediately if fever, throat, or mouth lesions (symptoms of blood dyscrasia); sudden v gain (water retention); skin reactions; black or tarry stools or evidence of intestinal hemorrhage occur. Make regular blood c Discontinue the drug immediately and institute countermeasures white count changes significantly, granulocytes decrease, or imm forms appear. Use greater care in the elderly and in hyperten

Adverse Reactions: The most common are nausea, edema and rash. Swelling of the ankles or face may be minimized by withhc dietary salt, reduction in dosage or use of diuretics. In elderly pa and in those with hypertension the drug should be discontinued the appearance of edema. The drug has been associated with pept

· 280-lb. tackles—or 108-lb. housewives—Butazolidin alka can hasten recovery from the onizing pain of shoulder bursitis.

not for every patient. Check carefully the Contraindications, Warning and cautions shown below.

d adverse reactions may occur. The most common are nausea, edema and rash. ely, agranulocytosis has been reported. All adverse reactions are listed below, too.

y-for-pay or workaday patients—when they come up with shoulder bursitis and your hical judgment indicates Butazolidin alka—go with it.

d watch the comeback.



nd may reactivate a latent peptic ulcer. The patient should be in- ed to take doses immediately before or after meals or with to minimize gastric upset. Mild drug rashes frequently subside reduction of dosage. However, rash accompanied by fever or systemic reactions usually requires withholding medication. ric rash has also been reported. Agranulocytosis, exfoliative atitis, Stevens-Johnson syndrome, or a generalized allergic re- n similar to serum sickness may occur and require permanent rawal of medication. Stomatitis, salivary gland enlargement, ing, vertigo and languor may occur. Leukemia and leukemoid ons have been reported. While not definitely attributable to the a causal relationship cannot be excluded. Thrombocytopenic ra and aplastic anemia may occur. Confusional states, agitation, che, blurred vision, optic neuritis and transient hearing loss have reported, as have hyperglycemia, hepatitis, jaundice, and several of anuria and hematuria. With long-term use, reversible thyroid plasia may occur infrequently. Moderate lowering of the red cell due to hemodilution may occur. 6509-V(B)R2

Butazolidin® alka

Capsules

100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate
1.25 mg. homatropine methylbromide

Dosage in painful shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
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Gas air conditioning's inherent low operating costs together with Public Service's *special low rate* during the warm weather months make it highly economical for almost all commercial and industrial applications. And our exceptional guarantee — two full years of free parts and service following the installation of a direct-fired gas air conditioning unit — ends maintenance worries. But where gas cooling really shines is in performance . . . the way it quickly responds with refreshing coolness even during the hottest, stickiest days . . . the way you can always depend on gas air conditioning to perform quietly and with maximum efficiency. Get all the facts about the flame that cools. Simply call your local Public Service office.

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fall 1967

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Season

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this issue: smog, smaze or smust...

Smog, smaze or smust...effects of air pollution on upper respiratory tract

Nathan Flaxman, M.D., Diplomate, American Board of Internal Medicine, Chicago, Illinois

In Los Angeles it is *smog* (smoke and fog). In New York City *smaze* (smoke and haze). In El Paso *smust* (smoke and dust). The original factor was smoke plus such natural phenomena as fog, haze and dust, but air pollution has mushroomed from a smoke problem in our industrial cities into a major economic, esthetic and public health problem that affects practically every American locality and citizen.[1,2] Respiratory disease, of course, is by far the most costly effect of air pollution, for contaminated air can aggravate our illnesses, deplete our strength and shorten our life span.[1]

The greatest problem in dealing with solid wastes is that they are not quickly returned to dust. To aid the decomposing process, the great bulk of such waste is burned, polluting our air in the process.[3] Dr. Jack McKee of the California Institute of Technology[4] has calculated that in Los Angeles County, which has more than six million people, about three pounds of gaseous wastes per person per day (on a dry-weight basis) enter the atmosphere. This is twice as much as solid refuse disposal and six times as much as the contaminants in waste water. It is estimated that in New York City, 730 pounds of pollutants, a little over half the size of a compact two-door sedan of foreign make, is annually thrown into the air for each man, woman and child in the city.[5]

Air pollution is an evident factor, not only in the common cold and upper respiratory disease, but also in chronic bronchitis,[2] pulmonary emphysema,[6] bronchial asthma,[7] pneumonitis and lung cancer.[8] Its effect on the incidence of pulmonary tuberculosis is unproved,[9] although it is conceivable that the presence of various materials polluting the air do this. A siege of smog in Denver, the "mile city," in December 1965 was accompanied by ratory infection that doubled normal absentee in schools, factories and city government.[10]

While air pollution is only one factor, it has be important in the causes of most of the afflictic the respiratory tract. This has been shown not by the Denver occurrence, but also by detailed s of respiratory illness in a small group of 313



n October 1962 to May 1963 when there were episodes involving the upper respiratory tract. attack rate of illness was related in time to in- sed concentration of both smoke and sulphur ide in the atmosphere of the district in which men lived.

er factors often mentioned, include exposure to e who have colds, exposure to extreme changes emperature, allergy and bacterial infection. vever, when low individual resistance due to of rest, overwork, fatigue, improper or unbal- d diet, previous illness and emotional stress are ded as causes, we enter the realm of somewhat ure relationships. Much more emphasis can be ed on the role of polluted air.

symptoms, signs and complications of involve- t of the upper respiratory tract, especially the mon cold, are the same regardless of the causa- factor. Swelling of the lining of the nose, the tchy dry throat, the discharge from the nose at watery then thicker, discolored and more tena- s, the eyes tearing, and frequent sneezing are art of the Number 1 human ailment. Concur- or residual sinusitis when mucus is trapped e, middle ear involvement due to interference drainage, laryngitis and bronchitis are compli- ns of the common cold. The primary interfer- is with a most important function of the nose— cleansing of foreign matter in the first line of defense" to prevent it from entering the breath- tract.

vever, the diagnosis and subsequent decision on to treat the patient so affected rests basically on relief of symptoms that cause him the misery. stuffed, runny nose, the clogged ears, and the h dry cough—all the symptoms that make com- cold sufferers feel miserable and interfere with r sleep—can be alleviated with medications of ral nasal decongestant/antihistamine combina- type. The burning sensation in the throat, sore-

For nature's hazards: nasal congestion due to seasonal allergies and summer colds



Triaminic® *syrup*

Each teaspoonful (5 ml.) contains:

Phenylpropanolamine hydrochloride	12.5 mg.
Pheniramine maleate	6.25 mg.
Pyrilamine maleate	6.25 mg.

For nasal congestion regardless of cause, you can bring quick, lasting comfort to your little patients with Triaminic Syrup. You may occasionally encounter these side effects: drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: the possibility of drowsiness should be considered by patients engaged in mechanical operations requiring alertness. Use with caution in patients with hypertension, heart disease, diabetes, or thyrotoxicosis.

(Advertisement)

ness of the chest and even chest pain can also be relieved by such medication. Rest in bed if there is fever (but confined to home at least), liberal fluids, uniformly warm surroundings and adequate humidity in the room, are all helpful adjuncts to the medication. Most common cold sufferers recover rapidly and are symptom-free in four to ten days.

Further treatment, altered by the fact that the affliction hangs on for more than the usual duration of the common cold, requires consideration of allergy, which is most frequently the prolonging factor. But air pollution itself may often be the culprit.

(Concluded on following page)



At the Third National Conference on Air Pollution held recently, it was emphasized that this subject had received more attention in the past four years than in all previous history. Spicer,[11] an active participant at this conference, reiterated that it behooves the practicing physician to be aware of trends in respiratory disease and to accept a major role in community action relating to air pollution and respiratory health. By taking a positive stand physicians have been instrumental in the development of anti-pollution legislation. An outstanding example is Los Angeles where major steps have been taken by abolishing coal burning, and even banishing oil burning, seven months a year. Natural gas must be used instead and it must be used by industry when available. Backyard incinerators have been abolished in favor of landfill disposal, and building incineration ended except for a few expensive smokeless furnaces.[10] Concerted action can be taken against particular industrial nuisances. One company that disregarded complaints discovered its error when thousands of its credit cards were returned by irate customers who decided to patronize competing companies.[12]

Summary. Respiratory disease is the most important and most costly effect of air pollution, whether termed smog, smaze, or smust. Air pollution is an economic, esthetic and public health problem that affects practically every American locality and citizen. New sources of air pollution are invisible and odorless, but the harmful gases and liquid droplets are there. Triggered by sunlight, some of these undergo mid-air chemical changes and the results are even more irritating to the upper respiratory tract. The symptoms, signs and complications, especially of the upper respiratory tract, can be readily aborted by modern medication but may be unduly prolonged by polluted air. In steps taken to prevent this, the practicing physician can take a major role.

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For summer allergies, sumr colds, or nasal congestion du almost any cause, you prescr quick r-e-l-i-e-f with Triami It's ideal for summer allerg

1. Acts in 15-30 minutes c to decongestant.
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Prescribing Information: Composition: Each white, beveled, compressed tablet contains: Quinine Sulfate 260 mg. and Aminophylline 195 mg. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.
References: 1. Shumon, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rowls, W., et al.: Med. Times, 87:818, 1959.
6/67 Q-706A

When the agitated geriatric disrupts the home...

His teen-age granddaughter won't invite friends home because of his outbursts.



for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

SANDOZ

His slovenly room and habits create more tension.

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His daughter can't please him. There is "just no living with him."

See following page for prescribing informatic

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Anxiety that seriously interferes with the individual's performance at work, at home, or in the community may be regarded as moderate to severe in degree.

Mellaril often recommends itself to the treatment of moderate to severe anxiety because it

- helps control the most frequent symptoms: marked tension, agitation, apprehension, restlessness, hypermotility
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- helps the patient maintain realistic contact with environment, closer harmony with family

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Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

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for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

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for

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The fast-disintegrating uncoated tablet gives relief in 15 minutes

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Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

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That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

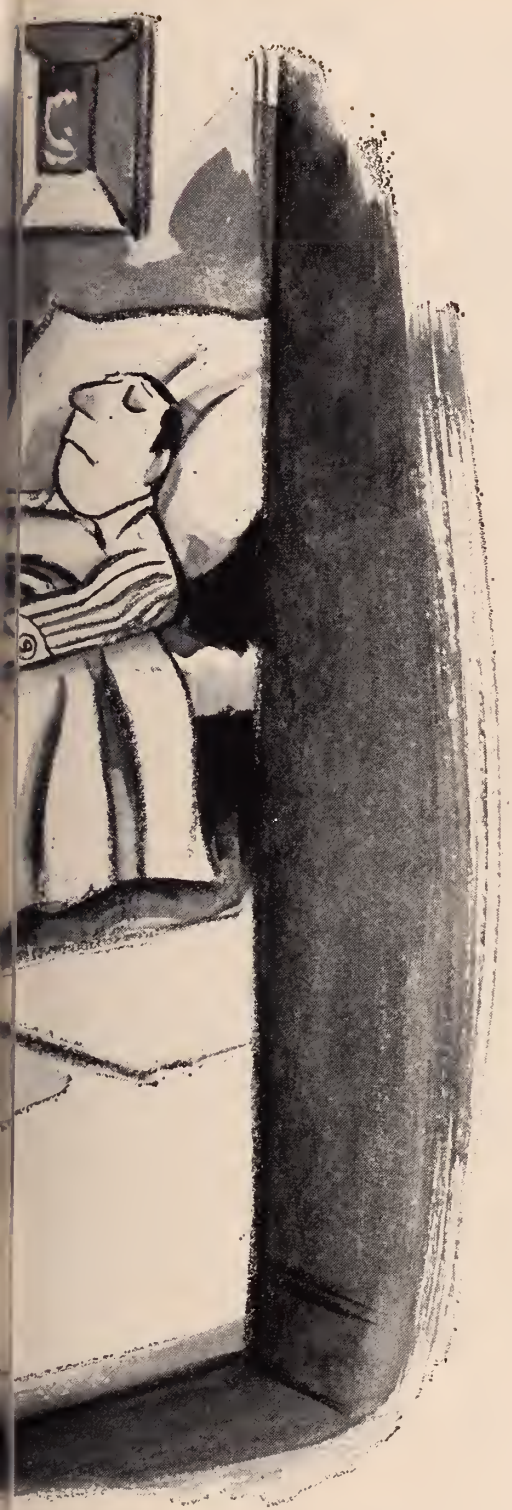
So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.





"George wants to know if it's okay to take his cold medicine now, Doctor, instead of seven o'clock?"



The long-continued action of Novahistine LP should help you both get a good night's sleep. Two tablets in the morning and two in the evening will usually provide round-the-clock relief by helping clear congested air passages for freer breathing. Novahistine LP also helps restore normal mucus secretion and ciliary activity—normal physiologic defenses against infection of the respiratory tract. Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result. Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

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ST. PETER'S GENERAL HOSPITAL
New Brunswick, N. J. 08903
NOVEMBER 15, 1967
1D Conference Room
9:45 A.M.

TOXEMIAS OF PREGNANCY
by
Russell DeAlvarez, M.D.
Director, Department Obstetrics & Gynecology
Temple University
Philadelphia, Pennsylvania

11:30 A.M.
LUNCHEON BUFFET

1:00 P.M.
CARCINOMA OF THE UTERUS
By
Clayton Beecham, M.D.
Director, Department Obstetrics & Gynecology
Geisinger Medical Center
Danville, Pennsylvania
Registration and Luncheon—$5.00

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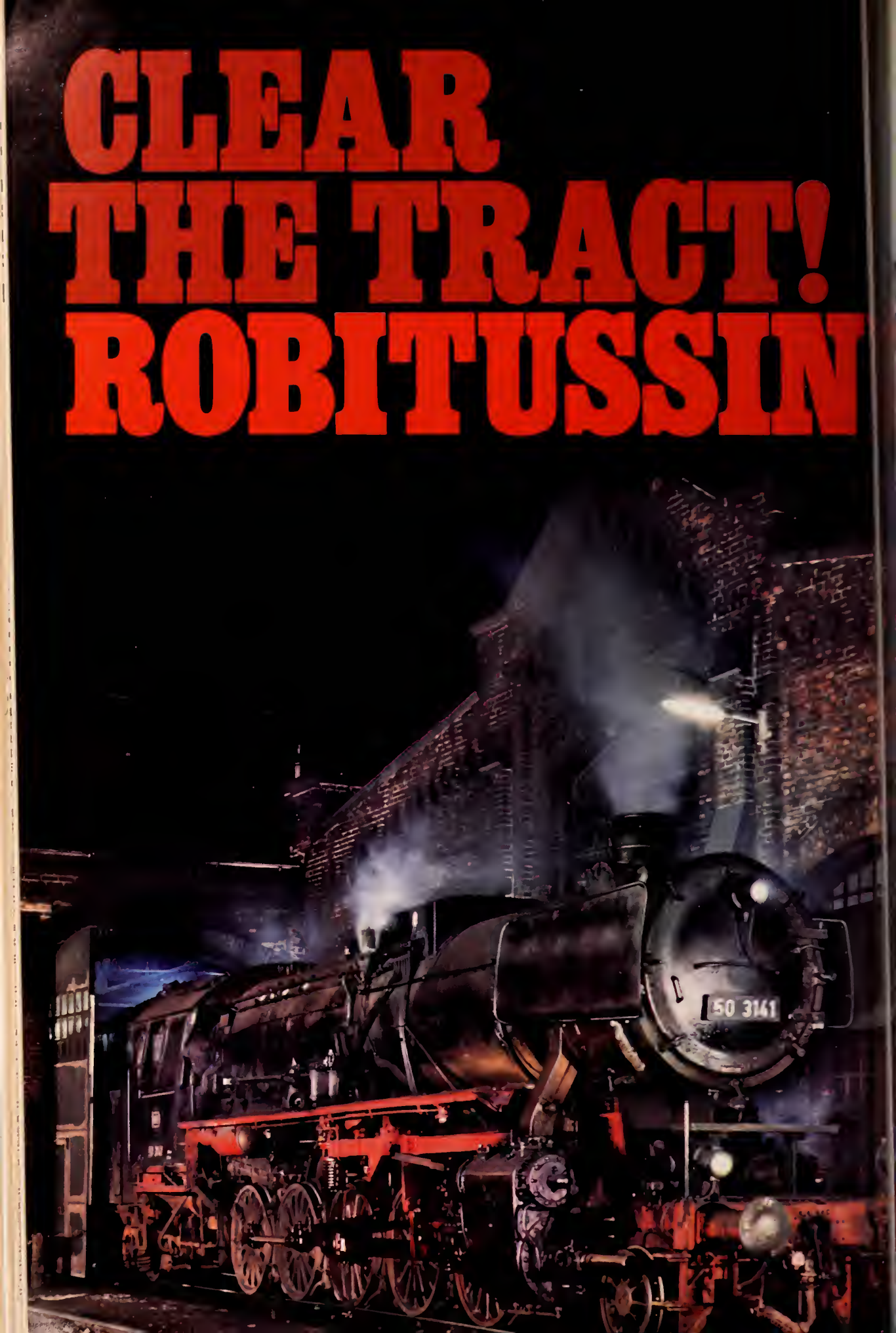
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For coughs of colds and "flu"
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Each 5 cc. contains:
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DEMULCENT	●	●	●	●
COUGH SUPPRESSANT		●	●	
ANTIHISTAMINE		●		
LONG-ACTING (6-8 HOURS)			●	
NASAL, SINUS DECONGESTANT				●

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A. H. Robins Company, Richmond, Va. 23220

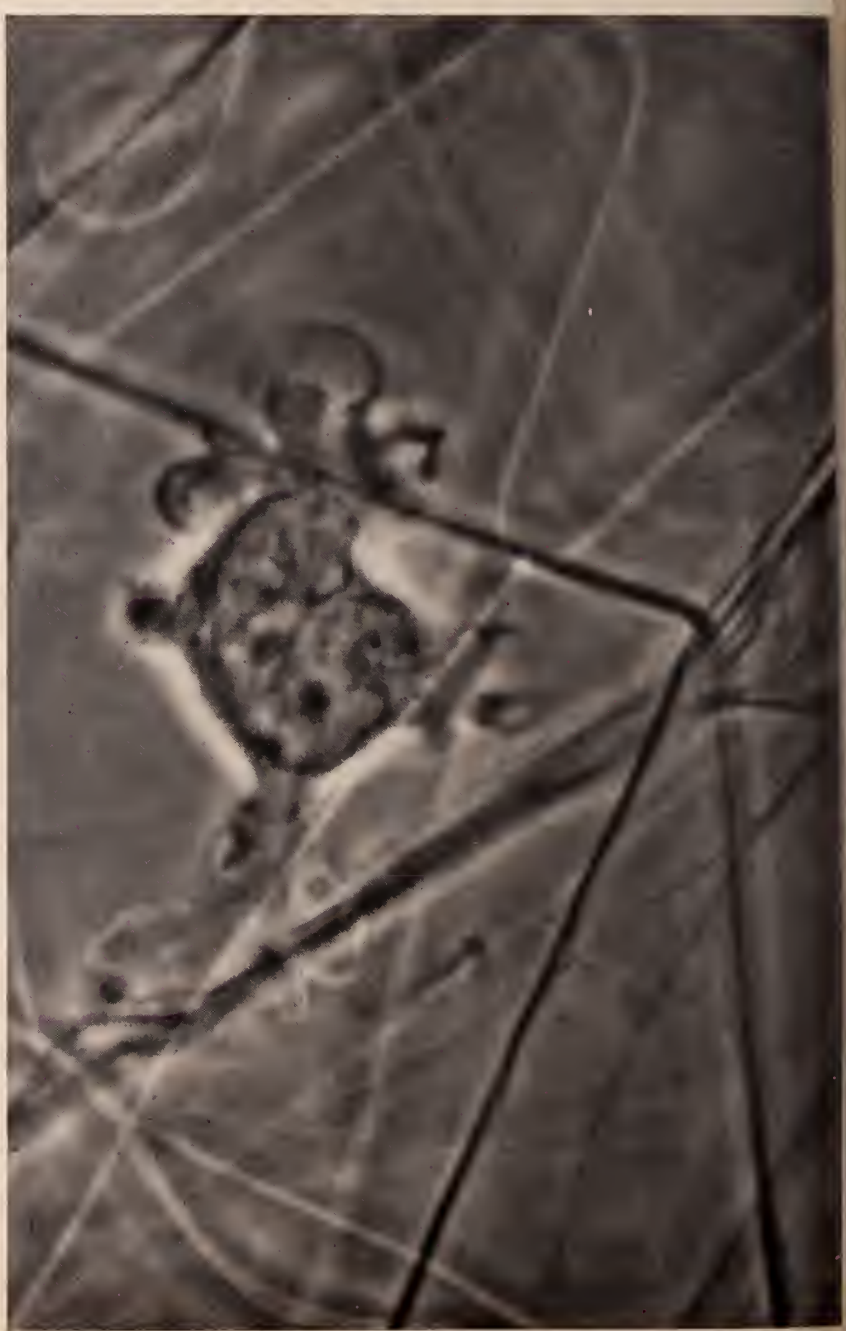
A·H·ROBINS

INFLAMMATION:
A cellular fight for life

A SYNTEX REPORT based on recently developed hypotheses about topical corticosteroids, including the cellular theories of inflammation by Thomas F. Dougherty, Ph.D., University of Utah.

You are looking at a fibroblast fighting for life. This cell—one of the most common found in connective tissue—has literally been poisoned by cytotoxins released from other cells that have ruptured. Soon, if the abnormal activity of this fibroblast does not cease, it, too, will rupture and die—one more casualty in the inflammatory wave of destruction precipitated by injury.

Until a short time ago no one had ever witnessed such a scene at the cellular level. Now, through advanced cinemicrographic techniques, it is possible to view and photograph the inflammatory process as produced experimentally in living animal tissue. This method permits new insight into the mechanism of inflammation and the role of corticosteroids in therapeutic management. Equally important, these techniques shed new light on factors that may make one corticosteroid more effective than another—factors that can be correlated with other chemical, biologic, and clinical parameters.

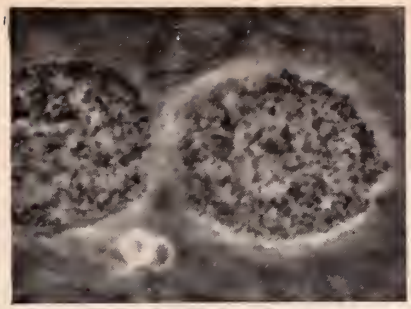


Visual evidence of how corticosteroids influence the inflammatory reaction

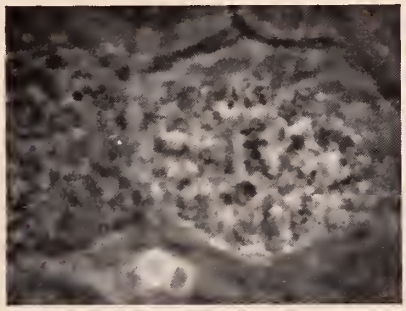
Working with phase-contrast cinemicrography on living animal tissue, Doctors Thomas F. Dougherty and David Berliner of the University of Utah College of Medicine have actually filmed cellular events that occur during the inflammatory reaction. This remarkable study* and additional work by these investigators, as well as by others, have established a new theoretical biologic basis for the antiinflammatory effect of the corticosteroids. (It must be noted that other theories, such as the lysosome or so-called "suicide bag" theory, have been postulated, although it is quite likely that there are more similarities than differences among the various theoretical models.)

The inflammatory wave of destruction

In this investigation an injurious injection of gelatin is used to set off an inflammatory reaction in living mouse tissue. What follows is a wave of destructive cellular activity that comprises the inflammatory response to injury. Mast cells (which contain heparin, serotonin and histamine) take up water, swell and rupture, releasing their contents, which are toxic outside the mast cell wall. These toxins, in turn, cause disintegration of other cells (such as fibroblasts) and the release of additional toxic material. Capillaries, too, take up water and leak unformed blood elements, causing edema. And polymorphonuclears, lymphocytes and epithelial cells invade the inflamed site. As a result of all these changes, the cellular environment reaches a state of turmoil.



Phase-contrast microscopy showing mast cell before injury.



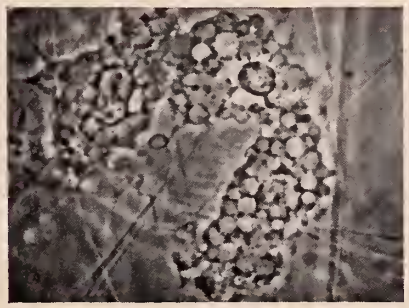
Mast cell (after injury) has broken up and released cytotoxins.

How corticosteroids change the picture

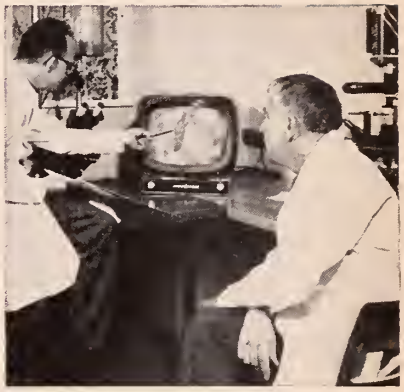
Corticosteroids appear to virtually stop the abnormal cellular activity that constitutes the inflammatory reaction. This permits the body's natural resources to clear up the inflamed area and repair the damaged tissue. This interpretation is supported by the fact that when the injurious gelatin solution is injected simultaneously with a corticosteroid – Synalar (fluocinolone acetonide) – the inflammatory pattern simply does not develop.



Fibroblast in high state of activity, much distorted.



Mast cells showing effects of corticosteroid action: cells are normal in size, shape and activity.



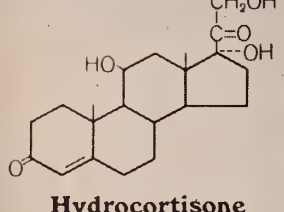
In summarizing his study Doctor Dougherty states: "...we also feel this work may explain why one corticosteroid helps a patient more rapidly and effectively than another. If it does, it is because one corticosteroid is the fastest, most effective inhibitor of the series of inflammatory events at the tissue level."

**A New View of Corticosteroid Action in Inflammatory Dermatoses*, a film based on this study, is now available from your Syntex representative.

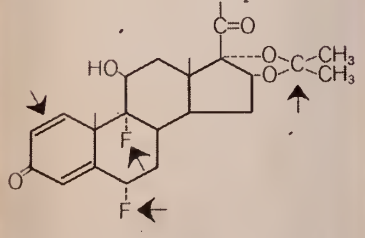
See last page for contraindications, precautions, side effects and dosage.

How advances in chemical design have achieved greater steroid potency

The chemical modification of corticosteroid molecules from the advent of hydrocortisone to the development of Synalar (fluocinolone acetonide) is a prime example of how biochemists can "design" to increase therapeutic activity and minimize undesirable side actions. Below, for example, we see the important changes that were made in reference to the hydrocortisone molecule to produce fluocinolone acetonide, one of the most active of all topical corticosteroids. As a result, a 0.01% preparation of Synalar (fluocinolone acetonide) has been reported to do the work of a 1% hydrocortisone product containing 100 times more cortiscosteroid. And it can often do it more effectively.



Hydrocortisone

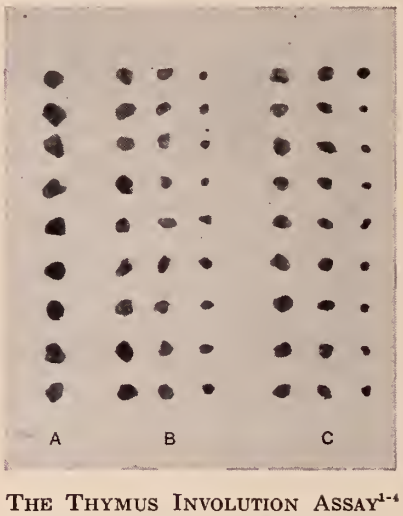


Fluocinolone Acetonide (Synalar)

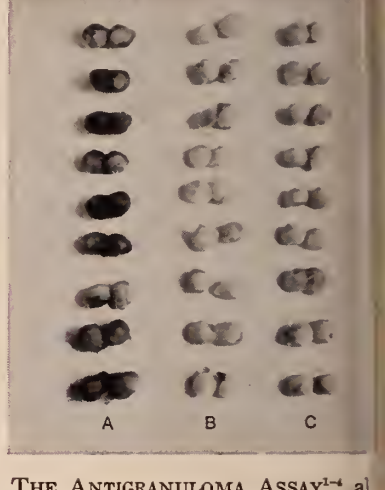
- *a double bond between carbons 1 and 2*
- *fluorine substitutions at* both *the 6-α, and the 9-α positions*
- *the addition of the acetonide at the 16-α, 17-α positions, thus providing one of the most potent topical corticosteroids available.*

How bioassay tests are used to "predict" therapeutic potential

Biologic assays are another tool used by researchers to help establish the relative activity of corticosteroids. To date no single method of assaying corticosteroid activity has emerged as the ideal "yardstick" for predicting therapeutic potential. Taken together, however, these methods have proved useful. When such tests are run on various corticosteroids, a definite order of corticosteroid activity becomes evident. Compounds with the highest order of activity may be expected to merit clinical trial to establish their high therapeutic potential. When assayed by these methods, fluocinolone acetonide (Synalar) emerges as one of the most active topical corticosteroids, milligram for milligram, available for clinical application today.



THE THYMUS INVOLUTION ASSAY[1-4] is run on adrenalectomized rats. The sizes of the glands are measured, and the degree of involution caused by the steroid is determined as an indication of its potency. In the above photo, the comparative involution of thymus glands achieved with hydrocortisone and Synalar (fluocinolone acetonide) is shown. Untreated controls (A) show normal size. Group B – injected with 1, 2 and 4 mg. of hydrocortisone – show progressively smaller thymuses as does Group C – injected with fluocinolone acetonide – but with only 1/500th the dose of hydrocortisone.



THE ANTIGRANULOMA ASSAY[1-4] al utilizes adrenalectomized rats. Gr ulomas are induced by subcutaneo implantation of cotton pellets either side of the thorax. The degr of granuloma inhibition achieved a steroid reflects its potency. T above photo shows the inhibition granuloma formation achiev with hydrocortisone and Synal (fluocinolone acetonide). Untreat controls (A) show large, red gra lomas adhering to the pellets. Gro B, receiving hydrocortisone a Group C, receiving fluocinolone a tonide, show little, if any, granulon formation. Fluocinolone acetoni produced the same effect as hyd cortisone with only 1/500th the do This assay, as well as the thym involution assay, measures system rather than topical corticosteroid a tivity. Nevertheless, results by the methods correlate well with other a says and with the milligram pote cies of topical steroids in currer clinical use.

Worldwide clinical experience confirms the predictable therapeutic potential of Synalar

t is particularly gratifying that the romise of the advanced chemical esign and high order of bioassay activity of Synalar (fluocinolone aceonide) has been confirmed by idespread therapeutic application. ndeed, the impressive clinical reponse rate of Synalar has been documented in no fewer than 232 papers rom 22 countries.

Representative Clinical Results with Synalar*

Efficacy Documented in over 4,000 Patients

Condition	Number of Publications	Number of Patients	Significant Improvement†
Contact Dermatitis	27	750	713
Eczematous Dermatitis	21	472	409
Seborrheic Dermatitis	18	442	426
Atopic Dermatitis	24	460	426
Psoriasis	36	1,699	1,510
Neurodermatitis	18	351	324
Total	144	4,174	3,808

*Complete bibliography on request.

†Expressed by the authors as excellent, very good, good, complete remission of inflammation, etc.

'RESCRIBING INFORMATION

'or initiation of therapy: Cream 0.025%, and 15 Gm. tubes, 425 Gm. jars; *for mollient effect:* Ointment 0.025%, 15 m. tubes; *for maintenance therapy:* ream 0.01%, 15 and 45 Gm. tubes, 120 m. jars; *for intertriginous or hairy tes:* Solution 0.01%, 20 cc. and 60 cc. lastic squeeze bottles; *for infected inammatory dermatoses:* Neo-Synalar® ream (0.025% fluocinolone acetonide, eomycin sulfate, equivalent to 0.35% eomycin base), 5 and 15 Gm. tubes. ONTRAINDICATIONS: Tuberculous, fungal, id most viral lesions of the skin, (inuding herpes simplex, vaccinia, and aricella). Not for ophthalmic use. Conaindicated in individuals with a hisry of hypersensitivity to any of the mponents. PRECAUTIONS: Synalar prepations are virtually nonsensitizing and nirritating. However, the solution may oduce burning or stinging when apied to denuded or fissured areas. In me patients with dry lesions, the soluon may increase dryness, scaling or ching. While topical steroids have not en reported to have an adverse effect pregnancy, the safety of their use on egnant females has not absolutely en established. Therefore, they should t be used extensively on pregnant paents, in large amounts, or for prolonged periods of time. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. When severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. SIDE EFFECTS: Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. The neomycin in Neo-Synalar Cream rarely produces allergic reactions.

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Rapid and predictable in antiinflammatory and antipruritic activity

Results often comparable to those of systemic corticosteroids with fewer hazards

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tear, moisten, compare–that's all!



EDITORIALS

Medical Student Leadership

On page 575 of this JOURNAL is a brief account of a summer project concerning the health of migrant workers. What made this a pioneer project was that it was developed and operated almost entirely by students at the New Jersey College of Medicine and Dentistry. These young people advanced their medical experience and education, of course. But they did something more. They learned that medicine is a social science, that the physician has a concern with the health of people who can't afford much private medical care, that public health can be a rewarding field of practice, and that physicians can be sound community leaders. Our medical students were not the only collegiate participants. The staff included law students, dental students, language teachers, personnel from our State Health Department, faculty from the New Jersey College of Medicine and Dentistry, officers of the State Department of Education, members of our Burlington County Medical Society, and other public spirited citizens. The whole project was unique, and we in New Jersey can be proud of the leadership of our medical students.

Hospitals, Medical Schools, And The GP

Elsewhere in this issue we publish a letter from the officers of the New Jersey Academy of General Practice, suggesting that one reason for the shortage of GPs is the specialty-orientation of most medical schools. The Medical Society of New Jersey and individual members are urged to get behind A-280, which would charge the two medical schools in this state with the purpose of "producing practicing family physicians."

The apparent unattractiveness of general practice is not due to economic factors. Recent studies (particularly by *Medical Economics*) have indicated that, in terms of gross and net income, the GP is well ahead of some of the specialists. This can hardly be the source of the difficulty. To some extent, perhaps, the problem may arise because family and general practice seem less glamorous than most of the specialties. But even here this would not seem to be a serious factor. Without half trying, any of us can think of a couple of medical specialties which are less than glamorous.

One factor is probably the long hours and the large number of patients the GP must see. He often gets the feeling that, to get through the day, he has to short-change some of his patients. Lack of recognition is also a factor, since the layman's idea seems to be that as soon as something gets too difficult for the family doctor, a specialist is summoned. This tends to downgrade the GP in the eyes of the public.

The writer of the letter suggests that medical schools are dominated by specialists. In fact, they are increasingly dominated by hospital-based, research-oriented specialists. Not only are the problems and skills of the GP alien to them, but they don't even grasp the daily life of the private practitioner of a specialty.

Perhaps the legislation supported by the Academy of General Practice will provide an answer. One wonders, however, how it would be possible to compel medical schools to produce GPs by act of the Assembly and Senate. If the legislation actually prevented either of the medical schools from doing research, it would harm the prestige of both institutions. Yet, too often this is what is meant by the charge that a medical school should concentrate on training practitioners, rather than pure medical scientists. Even if the focus were exclusively on the training of private practitioners, it would still be impossible to compel the alumni to stay in general practice.

Every patient who enters a hospital falls primarily within the jurisdiction of some specialty. Even if the hospital has a GP section, when the chips are down, the difficult or serious patient is referred to a specialist. In all candor, the doctor should ask himself: what condition might my wife or child have that would lead me to call in a general practitioner, if she or he were hospitalized? How many physicians have their wives delivered by a GP rather than an obstetrician? How many physicians who have a baby with an earache call in a GP rather than a pediatrician or otologist? We doctors have to make up our own minds about the acceptability of the general practitioners. So long as we ourselves think of the GP as a feeding station for specialists, we can hardly blame the general public for taking the same attitude.

Noncommercial Aspects Of Medical Advertising

With our present cynicism about Madison Avenue and all its works, many of us see medical advertising as simply a hard sell to lure money from unsuspecting patients. Actually it is more than that. The company which makes the product advertised (whether a drug or an appliance) has involved itself in planning, research, and preparation. It has to know the product, know what the physician wants, and, above all, know what will help the patient. The advertiser needs skilled advisers with respect to the artistry of the display. The company is bound by a burgeoning book of rules and regulations about the honesty of his claims, the effectiveness of his product, and the possible contra-indications and side effects. He has to pass the critical screening imposed by the officials of the sponsoring society. The Federal Trade Commission and the Food and Drug Administration keep a pair of eagle eyes on his advertising copy.

Critics sometimes make fun of doctors who learn about medical progress through advertising or through the information furnished by manufacturers' service representatives (to you, known as "detail men"). Actually, it is impossible for any physician to keep in touch with everything in his field, and the advertisers have developed considerable skill in extracting the essence of research studies. Naturally, they focus on results that support their own claims. But most researchers do that anyway, and the doctor is presumably sophisticated enough to weigh claims with some objectivity and reservation. No reputable manufacturer is going to risk his reputation by publishing false claims — and non-reputable ones don't get into the advertising sections of society-sponsored medical journals. A tour through the advertising pages of this, or any similar journal, is like a tour through the exhibits at a scientific convention. You are expected to read the copy with judgement and discrimination, just as you survey scientific exhibits. The advertising pages do not represent instant education. To that, there are no short cuts. But they are not simply a collection of extravagant puffs, either. They are a show-case of solid, usable, screened, and well-displayed information.

Retooling Your Clinical Skills

The AMA Clinical Session in Houston next month (November 26 to 29) offers really refreshing insights into clinical problems that you will find useful in your practice and professional duties. This meeting is especially designed to help us keep up-to-date on latest medical developments. Some truly outstanding medical teachers have accepted the invitation to participate in the scientific program.

For you, this Clinical Convention presents opportunities for tooling up your medical knowledge, for renewing associations with fellow physicians, and for catching a breather from your busy schedule. It promises to be a stimulating four days, worthy of your time.

ORIGINAL ARTICLES

A simple and clean cut guide-line is here offered on the management of polyps of the colon.

The Colonic Polyp: Observation Or Excision?*

David B. Miller, M.D., James J. Chandler, M.D., and William P. Burks, M.D./Princeton

Many colonic polyps are harmless and can be watched; 40 per cent of colons examined at autopsy contain benign polyps. But the observation pendulum has swung too far. Too many colonic polyps are now being "observed" too long. The physician and the surgeon must have guidelines to help decide which polyps can be "observed" and which should be excised without further ado. No one is concerned about the malignant potential of hemorrhoidal tags or hypertrophied anal papillae. These can be watched indefinitely. Nor is there any problem in deciding what to do for patients with polyps within easy reach of the sigmoidoscope, since the best treatment for these is excisional biopsy. The descending colon small polyp that is noted in an elderly man on a barium enema, however, may put his doctor on the horns of a dilemma.

Recent medical literature has offered numerous articles on the pathology and the malignant potential of colonic polyps. Welch[1] believes that adenomatous polyps are pre-malignant. Enquist[2] and Knoerschild[3,4] have both emphasized that one polyp in five or ten will disappear spontaneously. Most will show no sign of change, but at least one per cent will develop cancer in five years.

Turell,[5] Ackerman,[6] and Castleman[7] have all stated that adenomatous polyps are not pre-malignant but that their presence indicates that the colonic mucosa has an increased tendency to form types of neoplasms. Along this line, Dunphy[8] has pointed out that polyps often occur in association with a cancer and that known polyps have been known to disappear following the excision of the cancer. A less common type of polyp, papillary adenoma, has a recognized malignant potential. Many authors have reported that over 30 per cent will develop into frank cancer. While the malignant potential of simple adenomatous polyps is undoubtedly small, the question must be asked in each case in which a polyp is found, "what is the potential of this polyp being an early cancer; does the small risk of cancer outweigh the risk of surgery?"

There should be no disagreement in considering the patient who has a bleeding polyp. Also, the elderly bad-risk patient with a life expectancy of about 12 months would certainly not be a suitable candidate for removal of a colonic polyp. Although rarely, some stalked polyps have been found to be malignant. The characteristics of the head of the polyp and the number of polypoid lesions must be considered, but the one factor most influencing a decision whether to excise the polyp or not is its size. A one centimeter polyp has less than one per cent chance of being malignant and should not be excised. The mortality risk of doing a colotomy and polypectomy has been shown to be about one and one-half per cent; the risk of segmental resection of the large bowel is about two per cent.

* This work is from the Department of Surgery at the Princeton (N.J.) Hospital.

A colonic polyp that has been shown on two or more barium enema studies to be 1.5 centimeters in diameter, or larger, should be excised. The risk of malignancy in this case is at least six per cent and is most probably higher.

Cancer of the colon and rectum is the most frequent cancer diagnosed today. The uncorrected mortality figures for this particular lesion are still in the neighborhood of 30 per cent five year survival. Just as the sigmoidoscope should be used more often in the office examination of patients, with or without rectal symptoms, so must the scalpel be used earlier in those cases where a colonic polyp is found to be 1.5 centimeters in diameter or larger. The more frequent discovery of early cancers of the colon will be the result. And, until that day when these cancers are cured through new discoveries in immunochemistry, the only means of cure will be their resection.

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Medical Arts Building

Snoring Is No Joke*

About one out of eight Americans snore. This means something like 25 million snorers, women as often as men. The comic literature about snoring is endless. Plays, movies, vaudeville skits, and comics in general have poked fun at snoring down through the years.

There's a good chance that there's a snorer in your family. If so, you are well aware that it's not very funny. The assorted hisses, gurgles, buzzes, snorts, and raspings of the snoring nuisance hold the seeds for the ruination of an ostensibly happy marriage. Many married couples find it necessary to set up a schedule wherein one spouse tries to precede the other in sleep. Other couples proceed to separate rooms and possibly even the divorce courts.

For the most part snoring is generated while breathing either in or out during sleep by several structures in the nose and throat. The sounds are due to vibrations in the soft palate and other soft structures of the throat in response to inflowing and outflowing air. The frequency of the vibrations depends on the size, density, and elasticity of the affected tissues and on the force of the air flow.

A number of causes of snoring can be helped and even cured. Most snoring in children is cured by removal of enlarged adenoids and tonsils. A blocked nose may lead to mouth breathing and snoring. Sometimes this can be corrected by minor surgery. If snoring is caused by nasal congestion due to the common cold, sinus trouble, or hay fever, nose drops or antihistamines sometimes can bring relief to the sufferer and may stop snoring. Many people snore only when sleeping on the back. Any method that keeps the sleeper on his side or face can help.

There are factors that may affect the tone of the tissues of the throat and result in snoring. These include too much smoking, overwork, fatigue, obesity, and general poor health. The largest group of offenders are the elderly, presumably because they lack tissue tone.

* From the May 1967 issue of *Today's Health* (AMA).

Although ocular disabilities may make reading more difficult, they are not, by and large, say these authors, primary factors in dyslexia.

Ocular Aspects Of Reading Disabilities*

Alfonse A. Cinotti, M.D./Jersey City and Walter T. Rados, M.D./Newark

As the technologic and cultural aspects of our civilization become more complex, the necessity for mastering the comprehension of the printed word assumes increasing importance. Occupationally and socially (with rare exceptions) one's place in, and usefulness to, our society is proportional to the extent and quality of his education. Progress in education rests on ability to read and to comprehend what is read. Thus, the individual who is unable to master these skills is handicapped at least to the same extent as one with any other severe physical or psychologic difficulty.

The problem of dyslexia and related learning disorders therefore is of paramount interest to the physician, the psychologist, and the educator, to mention but a few. Many theories have been offered about the etiology of this condition and many modalities of treatment have been suggested.

Since vision plays a primary part in the act of reading, many have equated difficulty in learning to read with visual disorders. The primary purpose of this paper is to examine the part that visual disorders play in the cause or aggravation of reading difficulties.

The blind child or the child with extremely low vision will be readily apparent to the observer. Regardless of the cause of his difficulty, he is placed in the appropriate environment and given the proper educational materials. He will then, in the absence of other disabilities, often show little or no difficulties in acquiring the necessary skills. We are more concerned here with the pupil who has a useful level of vision and the part that visual disturbances may play in retarding his educational progress.

Emphasis has been placed on the role of uncorrected refractive errors. The individual with hyperopia obviously has to make a greater accommodative effort than the nonhyperope, in order to obtain a clear image. Furthermore, this effort is more difficult in proportion to the amount of hyperopia to be overcome, and also to the length of time that this effort is required. The classic symptoms of asthenopia (head or brow-ache, fatigue, blurring, and failure of attention) may well be seen in the hyperopic student whose refractive error goes uncorrected and who is required to do prolonged reading. Nevertheless, a moderate amount of hyperopia can be considered normal at the age level of the early school years and the amount of accommodative effort required at this time is in most cases insufficient to produce symptoms. The fact remains that uncorrected hyperopia may produce these symptoms, and a proper evaluation and adequate correction may help some individuals. At times the child who shows little or moderate manifest hyperopia will be found to have a comparatively high degree under cycloplegia and the desirability of cycloplegic examination cannot be over emphasized.

* Read before the Section on Psychiatry and Neurology, Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 15, 1967. This work is from the Division of Ophthalmology, New Jersey College of Medicine, and from the Motility Clinic, Newark Eye and Ear Infirmary.

Astigmatism presents a blurred image to the eye involved and (except in cases of small degree) may be a cause of blurring and asthenopia following ocular effort. Here again proper examination including cycloplegic refraction will reveal the extent of difficulty and the necessary measures for its correction.

Myopia, paradoxically, is of little importance in reading difficulties since the child need only move the print inside his far point to obtain a clear image. Furthermore, the comparatively large print used in early readers makes a high degree of visual acuity unnecessary. This is not to say that the myopic individual should not be corrected. Distance vision is at least as important as near, and the myope is blurred for distance in proportion with the amount of myopia extant. Furthermore the uncorrected myope tends to withdraw into himself since he is handicapped in this blurred environment. One hesitates to propose spectacles as a preventive or cure for introversion, but nevertheless they can play a significant part in such cases.

Pseudomyopia occasionally causes visual disabilities. It is usually associated with accommodative spasms or high degrees of exophoria. In these cases the child is unable to relax his accommodation on changing from near vision to far vision and after prolonged reading develops blurred vision which can be improved temporarily with myopic spectacles. If these lenses are prescribed the child will soon show further accommodative excesses which will necessitate an increase in the correction. A proper examination under cycloplegics will reveal the nature of the difficulty which requires psychotherapy.

The extent to which disorders of muscle balance and fusion are involved in reading difficulties is a matter of great controversy. While almost all will agree that the situation of two eyes seeing equally and being used together is at least highly desirable, this does not imply that reading difficulties will follow if this situation does not exist.

For example the child with an amblyopic eye or with alternating suppression found in most heterotropias will probably have few (or no) symptoms arising from ocular effort, assuming that any necessary correction for refractive error has been given — just as the monocular individual will have no reading difficulties arising from the fact that he is one-eyed.

Patients with intermittent heterotropias or hyperphorias may well exhibit symptoms of asthenopia due to the effort involved in maintaining ocular alignment and fusion. In particular those with hyperphoria, convergence insufficiency, and with so called "A-type" exophorias and "V-type" esophorias, in which the amount of deviation increases in the reading position will often be unable to maintain ocular effort for any great length of time.

The desirability of correction of ocular muscle imbalance, with its attendant fusion difficulties and frequent monocular suppression and amblyopia *ex anopsia,* or alternate suppression is not questioned here. The use of the proper lenses, miotics, orthoptics, pleoptics, and surgery where applicable is not to be quarreled with, nor is the necessity for early detection and therapy in order to achieve the best results.

Dunlap[1] reported on the surgical treatment of 40 patients with small muscle imbalances with moderate improvement of measured reading performance. These patients were chosen from the large group of retarded readers who had normal or above normal intelligence and in whom no other cause could be found. It is his contention that the work required by the individual to control the muscle imbalance leads to inefficient reading mechanics. While one cannot propose surgery as a cure for reading difficulties, it would certainly seem that some pupils suffer from impaired reading efficiency due to such problems.

Benton[2] in a study of 1500 children over a seven year period found that 10 per cent had primary or congenital dyslexia and these required highly specialized remedial reading teachers. Binocular abnormalities were found

in 77 per cent. Half of these children were treated by patching or blurring the non dominant eye with cycloplegics and given remedial reading instructions. Half of them showed remarkable improvement and 39 per cent moderate improvement.

Goldberg[3] and Park[4] do not feel that fusional problems are real factors, they point out that suppression of one eye is easy for a child to achieve if it becomes bothersome. Stromberg[5]-Bear[6] showed no correlation between reading efficiency and ocular muscle balance. Guber[7] could find no correlation between fixation patterns and binocular co-ordination by ophthalmographic records. They concluded that poor binocular co-ordination can become a problem when reading, only if a patient has not been able to develop some form of compensation, and that binocular reading skills are no more effective than monocular reading patterns. Faulty eye movements as seen during the act of reading are a symptom of poor reading ability and not a cause, so that treatment directed at producing smoother eye movements will not materially improve the condition.

Actual dyslexia is inability or decreased ability to acquire the necessary skills and comprehension required in the learning process. This is to be distinguished from those disorders which cause difficulty in maintaining the ocular efforts required in reading.[2] The ocular disorders mentioned above all fall into the latter category and have no bearing on actual dyslexia. Should these coexist with dyslexia they will of course aggravate an already severe problem. Indeed, even if no difficulty exists in acquiring learning skills, these disorders will interfere with the efficient utilization of these skills. Critchley[9] discounted most suspect etiologic factors and assigned the cause as genetically determined. Other problems, he suggests, merely aggravate the situation.

The value of much of the therapy so far proposed is, at best, controversial; and, at worst, sheer nonsense. These disorders are often diagnosed and treated by persons with no training or capacity to work in a field where accurate neurologic and psychologic diagnosis and treatment are necessary. Furthermore, results of therapy cannot be honestly evaluated when allowances for maturation, as well as the beneficial effect of other forms of simultaneous treatment, are disregarded.

Reading disabilities are best approached by a multi-disciplined team, including the neurologist, the psychiatrist, the ophthalmologist, the otologist, the educator, the psychologist, and the social worker. A meticulous medical and psychological, as well as educational evaluation, must be carried out; basic and secondary etiologies identified; and a program of therapy worked out for each pupil in accordance with the findings.

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3285 Kennedy Boulevard

How can a general hospital develop a section or division of inhalation therapy? Here's how:

Administrative Organization Of A Division Of Inhalation Therapy*

Martin L. Norton, M.D./Detroit, Mich.†

The organization of an inhalation therapy section as part of the Department of Anesthesiology within the structure of a hospital leads to certain basic requirements essential to the functioning of such a department. Basic authority must originate with the Medical Board. The progress of medicine has as its corollary a significant increase in the life expectancy of man. Thus, we are faced with a population increasingly in need of therapy for emphysema, progressive pulmonary fibrosis and the pneumoconioses. Problems of the respiratory management of the asthmatic become more difficult with the increase in the geriatric population. And there is need for the cardiorespiratory preparation of the preoperative patient. These are only a few examples of the need.

Administratively, one is faced with the allocation of equipment according to (a) specific patient need (both in-patient and out-patient) (b) equipment availability and (c) nursing feasability. The problem of releasing equipment when it is no longer indicated medically (and thus freeing it for another patient's care) is a particularly sensitive area. This is exemplified by the tank of oxygen and its associated paraphernalia remaining by the patient's beside long after the patient's immediate needs have been met. It thus serves only two purposes: it denies another patient the use of this equipment; and it escalates hospital costs. Too often inhalational therapeutic orders are written without regard to availability of properly suited equipment, adaptability of therapeutic units, and the knowledge, ability, and skill of the individual technically administering the ordered therapy.

The Medical Board should authorize the development of such a section, division, or department with sufficient independence to provide needed services for the patient within the context of administrative responsibility. In many institutions, this division has been placed under the Department of Anesthesiology. The following suggested proposals are presented for a basis on which to build a Medical Board enabling resolution:

1. That a Division (Section) of Inhalation Therapy be organized as a formal unit as an integral part of the Department of Anesthesiology. This unit will be established on the medical level as an administrative as well as a consultative service.

2. That the director of this section be the Director of the Department of Anesthesiology (or other physician of equivalent background), who will have special knowledge and experience in the various modalities included within the responsibilities of the Department.

3. That the Director of the Division (or Section) of Inhalation Therapy be empowered to supervise and direct technician and nursing personnel; to review equipment usage and allocation as indicated for optimum patient and hospital usage; to review equipment and make recommendations for servicing, repair, and purchase; to provide private case consultation services; and to establish regulations in conjunction with administrative recommendations governing the unit and/or its equipment.

4. That this unit will include the following aspects of medical care with the advice and guidance of the Department of Anesthesiology, the Chest Service of the Hospital, and Disaster Committee:

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(a) Oxygen therapy.

(b) Respirator therapy.

(c) Medical hypothermic management (differentiated from anesthetic management).

(d) Measurement of clinical physiologic parameters required to evaluate effectiveness of Division of Inhalation Therapy equipment usage. (This provision does not abrogate nor duplicate the responsibilities of the Respiratory Service nor consultative activities of other specialists in the cardiorespiratory disciplines).

(e) Assistance in emergency situations in conjunction with the Disaster Committee of the hospital.

5. That this unit will develop a regular instructional program for the personnel of inhalation therapy and nursing; and for interns and residents — subject to the approval of the Director of Medical Education.

6. That a review of the income afforded the hospital from the technical services of the Division of Inhalation Therapy will be instituted with a view to establishing a budget for the purchase and maintenance of equipment and supplies, and the provision of adequate personnel within the Department. The Medical Board will establish a budget for the Division of Inhalation Therapy.

Provision must be made for extra-departmental cardiorespiratory consultancy services with no additional limitations than that of equipment availability and the formal request for such consultations. Fees should be charged for equipment usage and technical services rendered, as well as private medical consultancy activities. Thus, the hospital is assured of the fiscal stability of the department while the character of fee-for-service medical private practice is not disturbed.

Obtaining the support of the Medical Board for these principles is facilitated if specific intra-departmental regulations are presented as an example of the internal organization plans for the unit. This is vital to the understanding of the Department, and the interpersonal relationships to be developed with other Departments. The following will exemplify such rules and regulations.

(1) Administrative services:

a. A service to and of the hospital, e.g., allocation of equipment, education of personnel.

b. The hospital levies charges for the Division of Inhalation Therapy technical services.

(2) Medical Professional services; service cases:

a. Consultations to be by residents of the correlatively interested departments under guidance of the Division of Inhalation Therapy.

b. All cases should be reviewed by the Director of the Division of Inhalation Therapy.

c. No charge should be made for these services.

(3) Medical Professional services; private cases:

a. A consultative fee-for-service basis, on request only.

b. The hospital charges for the use of equipment and the technicians' services. The physician bills only for his professional medical services.

(4) All equipment must be tagged and numbered.

(5) Monthly inspection of all equipment should be by the Engineering Department.

(6) All equipment should be periodically tested for contaminants by the Laboratory or Pathology section.

(7) Daily records must be kept with respect to varied gases and cylinders available (an adequate reserve supply must always be assured); records should always show the location of equipment throughout the hospital and must reflect inventory changes and maintenance needs.

(8) Discontinuation of therapy and equipment usages:

a. Hypothermia — daily re-ordering required.

b. Respirators — daily re-ordering required.

c. Oxygen tents, vaporizers, and humidifiers should require 48 hour renewal orders.

(9) Basis for determination of equipment availability must include: consultation recommendations, physical availability, adaptability to physical site or situation, technician controllability, nursing feasability, and, of course, urgency of need.

(10) Nurse supervision is in conjunction with the office of the Director of Nurses and includes instructing and assisting nursing personnel in the care and management of Division of Inhalation Therapy equipment and activities.

Institution of therapy should require consultation request. This consultation may be administrative (i.e. determination of technic most suitable or available, e.g. blanket, wind tunnel, ice pack) or medical (management, indications and contraindications, follow-up, etc.)

The Division of Inhalation Therapy should include interested and capable active members of other related departments on the staff of the Department of Inhalation Therapy with privileges limited to activities within the division. This will then present a multi-disciplinary group of physicians for better patient care and integrate interests of the various departments.

A clear delineation of the spheres of activity must be made in the plan for organization of a division of inhalational therapy.

Medical — Surgical Hypothermia Team is called for:

a. General — evaluation of indications and preparation.

b. Regional — determination of mode of hypothermia, such as blanket, ice pack, wind tunnel, ice water baths, cold enemas, gastric cooling — (Wangenstein), vesica urinae cooling and intravenous cooling by cold blood and other solutions.

High Pressure Oxygen Therapy is in two phases.

Phase I includes:

1. Bibliography

2. Development of comprehensive familiarity and review of all phases of programs in other institutions.

3. Source for data leading to future recommendations.

Phase II includes the development of a program integrating high pressure oxygen therapy into medico-surgical management of the patient.

Also needed is a ventiliatory Assistance Program (non-anesthesia) as follows:

a. Cardiac arrest and other emergency assistance:

1. Portable respirator availability.

a. Bird-oxygen drive.

b. Bag and mask, e.g. pulmotor.

c. Mouth to mouth respiration.

2. Educational program for all personnel involved (nursing department, interns, residents).

3. Catastrophe or Disaster Committee participation.

The development of a "Respirator Center" is limited to needs and plans of the hospital. These might include:

1. Emerson bag respirator.

2. Chest cage instruments, e.g. Monahan cuirass type.

3. Development of program for care of respiratory disease patients, e.g. emphysema, asthma, and pneumoconioses.

4. Oxygen and humidifications, tents, croupette and isolette control in conjunction with Pediatric Department, nasal catheters, and face masks and hoods.

The pre- and post-operative surgical program is in conjunction with the Surgery Department. Included here are:

1. Pre-operative Cough-A-Lator® preparation of bronchiectasis patients; postural therapy; blow bottles; intermittent positive pressure breathing and Cough-A-Lator® high expiratory resistance airway pressure, and the evaluation of patients for thoracic surgery in conjunction with the Chest Service.

2. The post-operative program includes assistance in relation to a telectasis problem, pneumonitis, etc. Also covered must be the clinic preparation of private, service, and ward patients.

A "Coma Center" should be developed. The respiratory phases are in conjunction with Anesthesia, Urology, and other related departments. Consider also city, state, and regional Coma Center Programs, and therapeutic agent administration: antibiotics; surface active agents, e.g., mucolytics; and proteolytics, e.g., tryptar inhalations.

Other progress participation should include the Disaster, Civil Defense, or Catastrophe committees of hospitals, city, state, and region; Inhalation Therapy committees; and coordination with the State Societies of Anesthesiologists, the American College of Chest Physicians, and the American Association of Inhalation Therapists.

A "library" function includes a reference source compilation of data about respirators, humidifiers, hyperbaric oxygen therapy, hypothermia, and general inhalation equipment; the education of hospital personnel and, hopefully, the development of an approved school for inhalation therapists.

The department needs:

a. Office — available to physicians and patients alike (including examination treatment facility).

b. Secretarial services.

c. Informational brochure and letters to all departments about the new service, available facilities, program developments, and consultation services.

d. Related equipment including pulmonary function and other monitoring equipment such as oximeters, and carbon dioxide meters.

Summary

We have presented herein basic concepts to be considered in the development of a medically oriented Division of Inhalation Therapy. While specific recommendations are included herein, one must recognize that factors such as the historical development of the unit in any particular hospital situation may require proposal modifications. The basic principles presented, however, should provide a firm foundation upon which to build a superstructure of administrative responsibility and improved patient care that will prove to be a credit to the medical community.

1400 Chrysler Freeway

Here we are reminded of a rare, but significant untoward effect of therapy with cardiac glycosides.

Gynecomastia Following Digitalis Administration

Ellis P. Singer, M.D./Plainfield

Anorexia, nausea, vomiting, diarrhea, and yellow vision are the common clinical manifestations of digitalis overdosage. These are familiar to the practicing physician. Also well known are the conduction defects and arrhythmias which make up the electrocardiographic signs of toxicity. The somewhat less commonly reported, although not infrequently observed,[1] manifestation of gynecomastia following digitalis administration, deserves further attention and forms the basis of this case report.

Case Report

A 73-year-old man was first seen in February 1960 for an upper respiratory infection and a history of gross hematuria on two occasions in the past week. In 1957, gross hematuria and right flank and groin pain had occurred twice. An intravenous pyelogram showed normal function and there were no calculi except within the prostate gland. Physical examination then was within normal limits.

Further past history revealed appendectomy, age 40; gonorrhea, age 20; skull fracture, age 19.

Family history was insignificant except for one sister (age 78) living with diabetes mellitus. The patient did not use alcohol or tobacco, and took only an occassional aspirin. His blood pressure was 160/90. Skin, head, eyes (including fundi), ears, nose, throat, lymph nodes, neck, and chest were all negative. He had a grade two aortic systolic murmur. A palpable liver edge was noted three finger-breadths below the right costal margin. Urinalysis was negative; hemoglobin was 15 Grams; VDRL was non-reactive; and electrocardiogram was within normal limits. The chest X-ray was negative except for lipping of the dorsal spine. Further genitourinary investigation was refused.

He was given vitamins. In the last year, he reported nocturia and dribbling. Rectal examination showed increased benign prostatic hypertrophy. Blood pressure was substantially normal and only salt restriction was advised.

Physical examination in October 1964, showed atrophy of the left testes, benign prostatic hypertrophy, hepatomegaly four finger-breadths below the right costal margin, albuminuria, five ounces of residual urine, and a small area of neurodermatitis of the left ankle and arm.

Because of hepatomegaly and contemplated genitourinary surgery, a Vim-Silverman liver biopsy was done. This showed a mild increase in lymphocytes and eosinophils in the portal areas. Occasional hepatocytes showed large hyperchromic nuclei and a few small areas of hepatocellular degeneration were noted, signifying minimal histologic changes.

The patient was given Hydromox® (Lederle). He tolerated a suprapubic prostatectomy with no ill effects. He was discharged on Hydromox, Feosol Spansules,® Mandelamine,® and hydrocortisone ointment for the non-specific skin rash.

Three weeks after discharge because of recurrent edema and multiple ventricular premature contractions, the patient was slowly digitalized with digitoxin 0.2 milligram Q.D. beginning January 5, 1965. In one week the ventricular premature contractions were gone. The patient was seen at two week intervals with no change in the physical examination, signs or symptoms of digitalis toxicity. The 0.2 milligram of digitoxin was continued daily. Four months later, the patient complained of swollen tender breasts and physical examination showed tender mammary tissue bilaterally which was increased in amount with no discrete masses.

On May 28, possible digitalis toxicity was considered and digitalis was stopped. On June 11, breast soreness was decreased although swelling persisted. On July 30, breast soreness, firmness, and swelling were greatly diminished. The patient was maintained on Hygroton® (Geigy) one tablet every other day. PBI done at this time was 5.8 micrograms per cent. Decholin circulation time was 15 seconds with a sharp end point. On September 10, the breasts were neither sore nor swollen. Digitalis leaf, 0.1 Gram every other day was begun and the patient has been maintained on this regimen continuously up to the present time. He was last seen on February 7, 1967, with no breast swelling or soreness.

Gynecomastia is rarely mentioned today as a manifestation of digitalis toxicity. In the 1961 edition of the Encyclopedia of Cardiology,[2] in the section on digitalis, no mention of gynecomastia is made in discussing the toxicity of cardiac glycosides. Other texts and articles mentioning this unusual finding all refer to the excellent reports of LeWinn.[3,4] Only

scattered case reports have appeared in the literature since then.[5,6] Doll's case[5] was in an 81 year old male who developed gynecomastia on digoxin 0.25 milligrams daily for two months before symptoms developed. Six weeks after digoxin was discontinued, these symptoms were gone. Calov and Whyte[7] reported an unusual case of generalized edema and mammary hypertrophy from digitalis, the breast being described as "swollen, tight, and tender with prominent vessels and enlarged, hard, lumpy glandular tissue." However many features of this report point to a hypersensitivity reaction: (1) Tincture of digitalis for eighteen months in 1940 and 1942; digitalis folium for one visit and digitalis tablets in 1945 for 5 weeks produced swollen fingers and feet which ceased after the drug was stopped. This indicates sensitization and then an allergic reaction. (2) Digitalis leaf 0.1 Gram three times a day producing symptoms in 48 to 72 hours. (3) Cessation of symptoms promptly in 48 hours after the drug was stopped. (4) Recurrent symptoms in one day when digitalis was tried again. (5) No symptoms on digoxin for 6 months, digoxin being a derivative of digitalis leaf and digitoxin.

LeWinn's reports[3,4] analyze gynecomastia in fourteen men between the ages of 53 and 77 years. He found no correlation between the preparation: powdered leaf, digitoxin, or lanatoside C, its dose, or duration and the degree of breast involvement. None of the fourteen men had ever received steroids. Histologic studies of the breast tissue in two cases showed fibroadenomatous hyperplasia in one, and only ductal epithelial proliferation in the other.

Hepatic function studies on seven of LeWinn's cases[4] showed minimal impairment. This, coupled with borderline prolonged magnesium sulfate circulation times (though clinical evidence of congestive heart failure was lacking), led him to postulate chronic passive congestion of the liver as a factor. The present patient had extensive liver function studies, all of which were normal. However, some minimal histologic abnormalities on liver biopsy in the face of hepatomegaly may represent compensatory hypertrophy in the face of subclinically damaged hepatocytes.

This factor, coupled with an age group in men associated with declining androgenic activity, and a slower excretion rate of digitalis in persons over 60 years of age,[8] may implicate an estrogen-like effect that digitalis steroids possess.

The cyclopentanoperhydrophenanthrene nucleus is common to estrogen, progesterone and the digitalis aglycones. In addition spironolactone, recently implicated as a cause of gynecomastia,[9] exhibits a structural similarity to the basic radical of the steroid hormones. Potentiation of this effect by impaired hepatocytes, unable to detoxify estrogen, may be responsible for gynecomastia. Unfortunately, no test exists for measuring the liver's ability to metabolize estrogenic hormones.

If age alone were a factor, one would expect a higher incidence with increasing age due to adrenal secretion of estrogen. This concept would be supported by histologic evidence of gynecomastia in 40 per cent of an autopsy series in elderly patients.[10] However, there was a definite association with prostatic and testicular abnormalities, adrenocortical hyperplasia, cirrhosis and diabetes mellitus. No association was found with malignancy, emaciation, paraplegia, pulmonary or renal diseases, or drugs, particularly digitalis, despite the fact that many of these patients were taking this drug.

All these conditions, (except prostatic abnormalities and unilateral testicular atrophy), have been ruled out in the present case. Other causes of gynescomastia,[11,12] such as refeeding after malnutrition, hypothyroidism, hyperthyroidism, spinal cord lesions, pulmonary tuberculosis,, Klinefelter's syndrome, Hodgkin's disease, bronchogenic cancer, and other drugs, such as reserpine and amphetamines, were also not present.

Conclusions

Gynecomastia following digitalis administration is infrequently seen and poorly under-

stood. A case is presented with this finding. Reinstitution of another form of digitalis did not reproduce gynecomastia. A review of the available literature is offered to elucidate possible mechanisms of pathogensis. It is hoped that this presentation will alert clinicians to the possibility of breast hypertrophy following cardiac glycoside therapy.

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1177 Park Avenue

The Deadly Motorcycle

As more motorcycles crowd the nation's streets and highways, the number of related injuries and deaths increases proportionately. In 1965 there were 1,580 motorcycle rider deaths in the United States, a 41 per cent increase over 1964.

According to the U.S. Public Health Service, the death rate for motorcycle accidents in the U.S. (considering the number of vehicles) is twice as high as the comparable rate for automobiles and other motor vehicles. The number of motorcycles on the roads has increased rapidly. Registration shot up by 71 per cent between 1960 and 1964 and by another 31 per cent between 1964 and 1965. Legislation governing the safe operation of these vehicles has lagged behind.

The AMA has made recommendations in an attempt to get some uniformity in the state laws on motorcycles, in view of the increased amount of interstate travel today. Some of the recommendations follow:

1. Motorcycle drivers should be licensed for driving motorcycles. An automobile driver's license should *not* be the sole qualification for driving a motorcycle.

2. All motorcyclists should wear helmets which meet the standards recommended by the U.S.A. Standards Institute. The helmet is one of the most important safety devices. Most victims in motorcycle accidents sustain head injuries.

3. Only one passenger, in addition to the driver, should be allowed to ride on a motorcycle; and then only if the motorcycle is properly equipped to carry a passenger.

4. There should be no more than two motorcycles operating side by side in a single traffic lane.

5. Rules governing automobile passing should apply to motorcycles.

6. Motorcyclists should drive with lights on *at all times.*

7. A motorcyclist is entitled to the full use of a traffic lane. Auto drivers should respect this right, and not force any motorcyclist off the road.

8. No motorcyclist under the age of 18 should be given a license unless he has successfully passed an accredited automobile driver's education course, obtained a regular auto driver's license and taken a motorcycle driving test. In no case should a license be issued to any one under 16 years of age.

A psychiatrist, who doesn't pretend to know all the answers, here offers a few sidelights on parenthood — the only profession for which no training is required.

The Doctor As A Parent*

Henry A. Davidson, M.D./Cedar Grove

Togetherness is fine — but how can the father spend much time with his children when he is on call morning, afternoon, and evening? If the kids begin to wonder who that man is, the doctor had better make the time. He can somehow find time for lesser things — and this, his channel to immortality, deserves a little attention too.

Whether the office is in the home — or in a downtown building — makes a difference too. When only a wall separates home from office, it is easier for the doctor to spend more time with his children. On the other hand, the children may have to be shushed every evening because office hours get a priority. Children in a home-office combination usually develop more poise than do the neighbor's children. They have to learn how to greet people, handle telephone calls, and even reassure anxious patients. Where the office is downtown and the home in the suburbs, the children are in about the same emotional and cultural environment as their neighbors — except that they usually see less of their father.

Usually the physician has top-drawer social standing. This affects the children, since more is expected of them. Their foibles become painfully noticeable. Juvenile delinquency, for instance, is frightening enough in any family. When it's a doctor's son who is caught up in this web, it becomes doubly poignant. Even the best friend has an unspoken and sadistic satisfaction out of seeing failure in the family of the man who tells other people what to do. In truth, delinquency is rare in doctor's families. Generally this reflects the simple truth that most physicians' kids are law-abiding. To a slight extent it is an artifact due to the way Society handles aggressiveness in children from "better" families. If some underprivileged kid in the slums breaks a store window he is likely to land on the juvenile court docket. If my son breaks a store window, I hear from the merchant and buy him a new window. This, of course, is not limited to the sons of doctors — it happens whenever the offenses seem "minor" and the parents are people of some community prestige.

There are one and a half million mentally defective children in the United States. While physicians have less than their share, some of those one and a half million are bound to be doctors' children. This is a devastating blow to any family, but it imposes a special turn of the screw when the child's father is a healer of others.

In the American culture, it is common for children of well educated parents to identify themselves with — and model themselves after — the parent of the same sex. Nearly all physicians want their sons to become doctors. (The ratio must be close to 100 per cent.) When a physician's son goes into another field, the father is usually chagrined and you get the feeling he has to apologize for his son's desertion from the Aesculapian brotherhood. Many fathers put on a brave front and explain how their son will be better off in business, or in teaching, but most of their friends will shake their heads and say "too bad." This curious situation has its gratifying side: it's reassuring to know that doctors are such good fathers that their sons use them as models. On the other hand, a little boy may

* Read before the English-language Medical Club in Guadalajara, Mexico, June 29, 1967.

be brain-washed into believing that he just has to be a doctor whether he wants to or not. Sometimes such a boy will go into medicine with less than a full heart, because he doesn't want to disappoint Dad. You don't have to be a professor to figure out that this is no way for a young man to embark on a career. The father knows it too. He knows he should give his son genuine freedom of choice; he knows that it isn't good to be bulldozed into going into a profession. But it is so pathetically easy for the father to kid himself into thinking that medicine is what the boy "really" wants. Mothers are less likely to exercise this pressure on their sons — but oddly enough, grandmothers are more likely to do so.

Doctors' daughters are generally a delightful lot. For reasons which any psychiatrist will gladly explain at your next dinner party, little girls have an easier relationship with their fathers than with their mothers. And most fathers agree that little girls are made out of sugar and spice and everything nice. Little girls in all families can usually twist Daddy around the well known little finger. But in doctors' families, the little girls are doubly proud of Daddy because he is so important — and they don't mind letting Daddy know that they are proud of him.

On the basis of a hurried count, I estimate that about eight per cent of doctors' daughters marry doctors. Since physicians constitute only two tenths of one per cent of the male population of the country, this is quite a disproportion. A doctor's daughter is more likely to marry a physician than to be one. Furthermore, medical practitioners are often more protective of their M.D.-sons-in-law than of their M.D.-sons. It is probably an extension of their greater tenderness toward daughters.

One of the more subtle problems in a doctor's household may be that of a domineering father. As a general rule, physicians tend to be aggressive men. Weak, passive ones are usually screened out by college and medical school. Any milktoasts who survive this double filter are likely to avoid the highly competitive arena of private practice and to seek the quieter pastures of research, government medicine, or teaching. Thus, there is a high titer of "strong" men among private practitioners. However, this does not mean that the strong aggressive man is going to have a timid wall-flower of a wife. Many wives are determined little creatures in their own right, and I have seen some of them leading "bossy" husbands around the way a little tugboat guides a giant liner. But inevitably, in many medical households, Poppa cracks the whip. Often the household schedule has to turn on the axis of *his* professional needs. This may make for a smooth running household machine but it may also lead to dominated children. The child who chafes under this kind of dominance may react in one of three ways. He becomes meek and fearful; or he withdraws into a world of make-believe where things are better; or he becomes sullen. This is one of the occupational hazards of medical fatherhood.

Counterpointing the "like-father-like-son" pattern is its opposite — the pattern of reversal. In its simplest form this is seen in the college athlete who in later life deplores the fact that he neglected his studies for sports. Now, in middle age, he loses ground because no one seems to have much need for a man who, 30 years ago had been an All-American fullback. So he determines grimly that come what may, *his* son will be intellectual. He soft pedals sports and enriches his son's curriculum with intellect. Sonny boy grows up to be a book-worm. At college he stands on the sidelines while the glamour girls swoon over the athlete. The sportsman is graduated and sixteen brokerage firms bid for him. Sonny boy now swears a mighty oath. If he has a son, *that* boy will be no book-worm. No sir, he will be an athlete.

Ordinarily this cycle does not develop in doctors' families. But occasionally it does. The physician sees that big money rewards go to big business men. Or he learns that the magnetic careers today are not in medicine but in nuclear physics or engineering. So, in rare cases, he steers his son away from the toil

and trouble of medicine; and then not until he has grandchildren is there another M.D. in the family.

Much more often however, the physician wants his son to be an M.D. In fact you would be surprised at how often a doctor dreams of founding a medical dynasty. If he is the first of his family to be an M.D. he hopes to be the charter member of such a clan. If he is the son or nephew of a physician, he does not want to break the chain. As a result, there are complex and burgeoning medical families in every large city, in most small ones, and in many famous "name" clinics. Though he may protest that he has no such interest, the dynastic dream often tinctures a physician's attitude toward parenthood.

When a child is sick, fatherhood usually overshadows physicianship. I know one doctor who was dissatisfied with his colleague's handling of his daughter's illness. He simply called in another physician. His wife suggested that it wasn't ethical to do it that way. Shouldn't they speak to the first practitioner before cavalierly displacing him? "When my child's health is involved, I am not interested in ethics — I'm interested in swift and effective medical care," retorted the anxious father.

The physicians's knowledge of medicine makes him a gloomy Gus when it comes to interpreting his child's illness. Headache due to eye-strain suggests a brain tumor. Anybody else's "virus" infection, becomes pneumonia when it involves *his* son. An ache in the leg that would be "growing pains" in the boy next door, becomes something solemn and dreadful like amyotrophic lateral sclerosis or leukemia.

At this point, do you want your money back? Do you feel cheated because you started to hear this talk by a psychiatrist and you still have picked up no tips on how to rear children? I know just how you feel. Indeed, one evening when my own children were infants, we were entertaining a well-known psychiatrist. As we sat down for dinner, the wail came from upstairs. I turned to my guest. "Sir," I said, "you are a distinguished psychiatrist. Tell me. If I leave this table and go upstairs, do I do wrong, because I let them feel that they can get whatever they want by crying? Or if I stay here, do I do wrong, because I let them feel that I am rejecting them just at the moment when they sail into the mysterious sea of sleep? What shall I do?"

"It's like this," said my guest, "when I started to do psychiatry, I had a speech called, 'Ten Commandments for Parents.' Somewhere in that speech was the answer to this very problem. When my first baby was a year old, I rewrote the speech and called it, 'Ten Suggestions for Parents'. When my second child was a year old, I threw the speech away and have never given it since. Next question?"

A century ago, Joseph Joubert said: "Children need models more than they need critics."

Box 500

Nursing Care of the Skin

The American Rehabilitation Foundation has now made available a profusely illustrated twenty-two-page brochure on *Nursing Care of the Skin*. This is written for use by intelligent laymen, and comes out of studies made by the American Rehabilitation Foundation, the Vocational Rehabilitation Administration, and the United States Public Health Service. Copies are available for 85¢ from the American Rehabilitation Foundation, 1800 Chicago Avenue, Minneapolis, Minnesota 55404.

You And The National Library Of Medicine

Leonard Karel, Ph.D.*
Bethesda, Maryland

When the National Library of Medicine was established in 1836 as the Library of the Army Surgeon General's Office, the Surgeon General was authorized to spend $150 "for medical literature." Today the Library [in a five-story contemporary building which it has occupied since 1962] is regarded as the world's largest in biomedicine. Among its holdings of 1,300,000 items, in seventy languages, are 315,000 monographs; 310,000 bound journal volumes; 285,000 theses; 168,000 pamphlets; and 4,500 reels of microfilm. It provides 175,000 interlibrary loans annually. Of these, 160,000 are photocopies of journal articles not available at the requesting local library. Reference personnel answer 10,000 personal inquiries, 10,000 phone inquiries, and 2,000 mail inquiries each year. Requests for 100,000 library items are made by 25,000 to 30,000 persons who use the reading room each year.

The Library is a major publisher of biomedical bibliographies.[1] It was developed as both a national and an international resource by Dr. John Shaw Billings, Librarian from 1865 to 1895. In 1922, it was renamed the Army Medical Library and in 1952 it became the Armed Forces Medical Library. In 1956, under legislation introduced by Senators Lister Hill of Alabama and John F. Kennedy of Massachusetts, it was transferred to the Public Health Service as the National Library of Medicine.

The Library was established by the Congress of the United States to assist in the advancement of medical and medically related sciences.

Toward fulfillment of its mission the Library (1) acquires and preserves books, periodicals, films, prints, and other library materials pertinent to medicine; (2) organizes these materials by appropriate cataloging, indexing, and bibliographic listings; (3) publishes and disseminates catalogs, indexes, and bibliographies; (4) distributes materials through interlibrary loans, photographic, or other copying procedures; (5) provides reference and research assistance; and (6) encourages, promotes, and supports activities to further the progress of medicine and of public health by strengthening existing services and developing new ones.

The Congressional mandate was strengthened on October 22, 1965, when President Johnson signed the Medical Library Assistance Act, Public Law 89-291 of the 89th Congress. This Act is an amendment to the legislation authorizing the establishment of the Library. It permits assistance to medical libraries for construction and renovation, for acquisition and for improvement of resources, for training of medical librarians and other information specialists, for preparation of publications, for research in medical library science, and for the development of regional medical

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[1] These include *Index Medicus, Cumulated Index Medicus, Bibliography of Medical Reviews, Biomedical Serials, Bibliography of the History of Medicine, and NLM Current Catalog. Other publications are Medical Subject Headings, National Library of Medicine Classification,* and the *Russian Drug Index.*

libraries. The Act also authorizes traineeships, fellowships, and special scientific projects by individuals or institutions.

The Library today serves as the principal national focus for bettering communication in medicine and the health sciences. It encourages the development of the existing system of medical libraries into a national medical information network. The Library has absorbed the Public Health Service Audiovisual Facility in Atlanta, Georgia. This facility has been renamed the National Medical Audiovisual Center and coordinates a national program in biomedical audio-visuals.

Access to the collection is facilitated through an interlibrary loan program. When libraries request loans through medical library channels, the National Library of Medicine lends books. It also provides copies of articles from journals which the requesting libraries do not possess and which are not available locally. There is no charge for this service or for other services except for special photography.

The Library collects materials comprehensively in some forty biomedical subject categories and selectively in many related categories. The collection, in which there are over 19,000 serial titles, is increased annually by 95,000 to 100,000 items. The Library now stores 360 million pages, of which 85 million are pre-1870. At least 10 million more are being acquired annually.

Its History of Medicine Division alone has between 60,000 and 65,000 printed works bearing publication dates earlier than 1801. Included in the collection are: an Arabic manuscript of the year 1094 on gastrointestinal disease; a collection of palm-leaf manuscripts from Ceylon, in Singhalese; works of Hippocrates and Galen; and letters written by George Washington, by Benjamin Rush, and by Florence Nightingale. Holdings also include 535 incunabula; 33,000 16th, 17th, and 18th century monographs; 1,600 17th century theses and pamphlets; 2,000 early American medical works; and an estimated 60,000 prints and photographs.

Computerized Library Services

Efforts of conscientious, busy practitioners to achieve and to maintain awareness of the most recent medical discoveries and applications have often led to many and continuing frustrations. The increase in the volume of medical literature and in the number of users has not been paralleled by equivalent growth of medical libraries and of information storage and retrieval methods and facilities adequate to catalog, index, store, and retrieve literature for use of physicians, scientists, and others. The Library uses computerization as a means of assisting, supplementing, and complementing traditional approaches to management of published biomedical literature and has pioneered in the use of computers for storage and retrieval of bibliographic information. A computer-based information storage and retrieval system called MEDLARS (Medical Literature Analysis and Retrieval System) is in use at the Library.

MEDLARS joins the professional experience of trained literature analysts and searchers with the processing capabilities of a high-speed electronic computer. The literature analysts, using terms selected from a thesaurus of approximately 7,000 terms, *Medical Subject Headings* (Part II of the January issue of *Index Medicus*), characterize each article by assigning to it a number of subject headings or "descriptors." Indexed articles are entered into the computer and transferred to magnetic tapes for storage, and for rapid retrieval. Currently, MEDLARS contains over 550,000 citations to biomedical journal articles published since January 1964. Half of these are in English.

Index Medicus incorporates 180,000 articles annually from nearly 2,300 of the world's biomedical journals. At the close of each calendar year, MEDLARS compiles *Cumulated Index Medicus*, a complete listing, with cross-references, of the citations which were printed in that year's issues of *Index Medicus*.

MEDLARS makes possible rapid machine searches of biomedical journal literature to obtain answers to reference questions that

cannot be handled expeditiously by manual searches. Machine searches which provide citations to medical literature in specific areas of interest are called "demand bibliographies." MEDLARS is responding to more than 400 highly specific computer search requests monthly. These requests are coming chiefly from physicians, teachers, and researchers in medical schools, hospitals, universities, and Federal research laboratories.

In addition to demand bibliographies, the Library collaborates with professional societies and other professional organizations in the preparation of "recurring bibliographies" — formally published, widely distributed bibliographies in specialized subject areas of broad interest. These recurring bibliographies are *Artificial Kidney Bibliography; Bibliography of Medical Education; Cerebrovascular Bibliography; Fibrinolysis, Thrombolysis, and Blood Clotting; Index of Rheumatology; Index to Dental Literature;* and *International Nursing Index.*

Although the Library supplies the sponsoring organization with citations retrieved periodically from MEDLARS on film ready for offset printing, publishing and distributing the bibliography — on a non-profit basis — are the responsibility of the sponsoring organization.

At frequent intervals, generally monthly, the Library selects from its demand bibliographies a few considered to be of general interest. Announcements of the availability of these bibliographies, called *NLM Literature Searches,* appear in the *Journal of the American Medical Association,* and other publications, including state journals. There is no charge for these *Searches.* Clinicians, educators, and researchers interested in receiving notices on new *NLM Literature Searches* may write to the Assistant to the Director, National Library of Medicine, 8600 Rockville Pike, Bethesda, Maryland 20014.

To enhance effectiveness of MEDLARS, the Library has provided its computer tapes and programs to university-affiliated centers which can make computer-generated demand bibliographies available locally or regionally to qualified practitioners, educators, and researchers. Decentralized MEDLARS stations are in operation at Harvard University, the University of Alabama, the University of California, the University of Colorado, and the University of Michigan. Others are being considered, and as regional libraries, authorized by the Medical Library Assistance Act, are identified, they, too, will be provided with MEDLARS search capability.

Physicians wishing to obtain demand bibliographies are encouraged to seek the advice of local medical librarians on suitability of the inquiries and on the preparation of requests which will elicit the information sought. The use of *Medical Subject Headings, Guide to MEDLARS Services,* and an expression of specific interests will help avoid retrieval of irrelevant citations. Thus, a request specifying animal experiments will help to insure that citations on human studies will not appear in the bibliography; similarly, specifying a single age group will obviate retrieval on all age groups. Citations may be arranged alphabetically by senior author, by journal title, by language, by subject headings, and by year of publication, and each citation can be printed with the "descriptors" assigned to it by its indexer.

The elapsed time between receipt of a request and mailing of a bibliography varies, but averages three weeks. MEDLARS does not produce abstracts. MEDLARS services are not provided for searches which can be readily accomplished by the use of published indexes, handbooks, and other reference materials.

Demand Bibliography Requests From New Jersey

During the period July 1966 — June 1967, inclusive, the National Library of Medicine responded to fifty-three demand bibliography requests from biomedical personnel in the State of New Jersey. Subjects ranged from the Effect of Aspirin on the Course of Infectious Disease, and Influence of Estrogen on Thyroid Function, to Pharmacology of

Diuretic Drugs. The distribution of the fifty-three requests was:

New Jersey Academy of Medicine	2
New Jersey College of Medicine and Dentistry	14
State University of Rutgers	3
Federal	2
Other (chiefly physicians)	32
Total	53

Summary

The National Library of Medicine, now the world's largest biomedical library, was established by Congress to further the advancement of medical and medically related sciences by the collection, dissemination, and exchange of scientific and other information important to the progress of medicine and of public health. It has become an international as well as a national resource for publications and other items relevant to medical communication, and renders service on a worldwide basis.

In January 1964, a computer-oriented information storage and retrieval system called MEDLARS (Medical Literature Analysis and Retrieval System) became operational at the Library. This system has improved the quality of *Index Medicus* and other Library-associated publications and has substantially reduced the time required for preparation and distribution of such publications. The MEDLARS store of biomedical journal articles published since January 1964 now exceeds 550,000 and is growing at an annual rate of 180,000 articles, taken from nearly 2,300 journals. Requests for computer searches come chiefly from physicians, teachers, and scientists in medical schools, hospitals, universities, and Federal research laboratories.

During the period July 1966 – June 1967, inclusive, the National Library of Medicine responded to fifty-three demand bibliography requests from biomedical personnel in New Jersey.

8600 Rockville Pike

Physicians In The Civil War

The April 3, (1967) JAMA is devoted to physicians as writers. The lead article, "Patriotic Gore" is by Paul Steiner, M.D. and speaks of medical problems during our Civil War. Diseases killed and disabled more soldiers than combat did. Physicians were hampered on the battlefield by lack of equipment and medicines, widespread infectious diseases, and the miserable living conditions of army camps.

It was during Sherman's march to the sea, somewhere between Atlanta and Savannah, that Union army doctors discovered the advantages of exercise for patients soon after surgery. The discovery was lost for 75 years, however, and had to be rediscovered by others before the army medical reports were uncovered.

Dr. William Watson of the Army of the Potomac wrote several letters home, telling of the fate of his Pittsburgh regiment. The unit of 1,000 men was riddled with disease time after time throughout the course of the war. During the battle of Chancellorsville, Dr. Watson himself was sick, but amputated until he lost count at a hospital that had to be moved five times because of shellfire.

The Civil War emphasized the importance of prompt medical care, but physicians continued to be scarce during the 19th Century in this huge, lightly populated country. Physicians had been few and far between since America's earliest days, and their scarcity helped the popularity of the "doctor book," the home medical adviser.

So long as dialysis programs are found largely in well-funded medical centers, many patients who need dialyses will die for lack of facilities. Community hospitals should more widely set up these enterprises.

Periodic Dialysis In A Community Hospital*

Seymour Ribot, M.D./South Orange

Periodic dialysis is a well-established means for extending survival and aiding rehabilitation of patients with irreversible renal insufficiency. During the past seven years, dialysis has been applied at an ever-expanding rate as more and more chronic dialysis units were established. Most of these[1,2,3,4,5] operate at medical centers, where the programs are maintained in large part by research grants derived from federal sources or private foundations.

Currently, however, only about 700 patients in this country and abroad are undergoing maintenance dialysis either as definitive treatment or in preparation for renal transplantation. Some 5,000 patients die each year of irreversible renal failure. These lives might have been sustained by currently available methods. Obviously, the present distribution of centers is not sufficient. One avenue of approach would be more effective utilization of community hospitals as local treatment centers or as training areas for home dialysis programs.

The Newark Beth Israel Hospital is an independent, privately supported community hospital currently engaged in an active dialysis program. The initial experience has been described previously.[6] This report deals with seven patients treated for varying periods up to fourteen months, at the time of this writing, March 1, 1967.

Materials and Methods

Seven patients were admitted to the periodic hemodialysis program at the Newark Beth Israel Hospital between January 1966 and April 1967. Selection was based on the existence of terminal renal failure unresponsive to medical management alone, the absence of other debilitating disease, and the presence of an opening in the program. Four of the seven were male. Their ages ranged from 22 to 44 years. Uremic symptoms had been present from one to ten months. None had previously undergone hemodialysis. Hypertension was present in all patients. Endogenous creatinine clearances varied from less than 1.0 to 4.4 milliliters per minute. Diagnosis of the primary renal disease was made in five patients on the basis of clinical history and in two by percutaneous renal biopsy.

All dialyses were carried out using the Kolff twin-coil artificial kidney. Access to the patients' circulation was obtained by way of a permanent indwelling Teflon-Silastic arteriovenous shunt implanted in the arm.[7] One patient had an internal arteriovenous fistula constructed according to the method of Cimino.[8] He required percutaneous venipuncture with 14 gauge needles at each dialysis session. Usual duration of hemodialysis was six hours. Patients were dialyzed at intervals of three to seven days, depending on urine output and tendency to develop edema. Dialyses were performed by a specially trained nurse with or without the assistance of a technician.

Management, in addition to periodic dialysis,

* From the Newark Beth Israel Hospital, Newark, New Jersey. Acknowledgement for their contribution to this paper is made to Arthur Bernstein, M.D., Martin G. Jacobs, M.D., Alan J. Lippman, M.D., I. Richard Zucker, M.D., and Judith Golden, R.N.

included a low-protein, low-salt diet, and fluid restriction. Antihypertensive drugs, sedatives and anticoagulants were employed as needed. Cation exhange resins for control of hyperkalemia were required on a few occasions. All patients were treated on an outpatient basis except when complications necessitated hospitalization.

Results

Patients were maintained on periodic hemodialysis for periods ranging from two to fourteen months. A total of 348 dialyses were performed, ranging from 11 to 117 per patient. Initial and present status of each patient is summarized in Table 1.

Six patients are currently considered to have responded well and have been partly or completely rehabilitated. In most cases, complications have been infrequent, temporary, and not disabling (Table 2). Occasionally more severe complications required hospitalization. In all but one case the hospitalizations were of short duration and the problems did not prove refractory. Excluding the initial hospital stay (which averaged 20 days), the average number of in-patient days per year was ten. One patient sustained multiple complications leading to intractable cardiac failure. He died after three months on the program.

In the patients who responded well, uremic symptoms tended to clear after the initial few dialyses. Nevertheless, most of them had frequent episodes of weakness, fatigue, pruritis and insomnia. These symptoms usually did not prove too distressing. The BUN (which averaged 160 milligrams per cent on admission to the program) fell to an average predialysis value of approximately 100 milligrams per cent. Each dialysis session normally produced an average decrease of 60 milligrams per cent in urea levels.

Bicarbonate and calcium values were kept within normal range while phosphorous concentrations remained elevated, in the range of 8 to 14 milligrams per cent. Total protein values averaged 6 to 7 Grams per cent with an albumin-globulin ratio of approximately 4 to 3.

Specific problems encountered were not unlike those experienced in other centers.

Cardiovascular

Common problems observed in oliguric patients were edema and the tendency to develop circulatory congestion. Daily urine output in each patient averaged 300 to 400 milliliters. Intake was restricted to 400 to 600 milliliters. Most patients found it difficult to confine their fluid intake to the prescribed amount on account of thirst, and usually gained two to five pounds between dialyses. Clinically, they would note bloating, headache, fatigue, and insomnia on the day prior to dialysis. Occasionally, noticeable facial and peripheral edema occurred. On several occasions frank circulatory congestion, with dyspnea, orthopnea, basilar rales and a cardiac gallop rhythm, was present. This occurred more than once in Patients 2, 3, 4, and 5. In most of such instances, the congestion was cleared rapidly with ultrafiltration and closer adherence to dietary restrictions. Five patients (Cases 3, 4, 5, 6, and 7) were maintained on digitalis. In one patient, cardiac failure became intractable and was the major contributing factor to his death.

Hypertension existed initially in all patients and was unimproved in all but two despite the use of antihypertensive drugs. Patients 1 and 7, with initial blood pressures of 200/120 and 180/100 respectively experienced return to near-normotensive levels without drugs. Assays of renin, angiotensin and aldosterone were not done.

Uremic pericarditis was present in five patients (Cases 2, 4, 5, 6 and 7) on entry into the programs and subsided in all after one or two months. One patient (Case 2) developed evidence of recurrent pericarditis with pericardial effusion after three months of dialysis. He required pericardiocentesis before improvement was achieved. Case 5 developed pericardial effusion terminally.

Hematologic

Anemia was present in all cases and maintainance of hematologic stability required transfusion of one to three units of whole blood per month. Optimal well-being was noted when the hematocrit value exceeded 25 volume per cent. Despite frequent transfusions and the presence of 20 microgram (mcg.) per cent of iron in the tap water used to prepare dialysate, serum iron levels in these patients ranged from 54 to 139 mcg. per cent. This is within the range of normal.

The hemorrhagic problems encountered were occasional bleeding from the arteriovenous shunts and one episode of gastrointestinal bleeding. Patients were anticoagulated with heparin while dialysis was in progress. Coagulation times were maintained at 2 to 3 times normal values. These returned to normal spontaneously, usually within two hours of completion of dialysis. Regional heparinization was used only if active bleeding was present at the time of dialysis.

In one patient (Case 1) mild gastrointestinal bleeding, manifested by the passage of tarry stool, was attributed to a duodenal ulcer. Although an ulcer crater was not demonstrated roentgenographically, his symptoms cleared with specific anti-ulcer therapy.

Neurologic and Psychiatric

Peripheral neuropathy existed on admission to the program in only one patient (Case 7). He experienced paresthesias of both legs, and was unimproved during the course of dialysis.

Detailed psychiatric studies were not made. Most patients adapted readily to the routine of therapy. Only one patient (Case 5) was unable to comprehend the necessity for fluid and diet restriction and felt that the liberties he took could be corrected by dialysis.

During the actual dialysis sessions, most subjects conversed or slept lightly. Only rarely were they able to engage in activity requiring more intense concentration, such as reading or writing.

Musculoskeletal

Muscle wasting, presumably on the basis of restricted protein intake and a persistent catabolic state, was significant in three patients (Cases 3, 4, and 5). Case 3 was maintained on a Giovanetti diet without dialysis for eight months. Continued weight loss and muscle wasting dictated the need for liberalization of protein intake and replacement on the dialysis program.

Arthritis was observed in only one patient, (Case 3) who experienced episodic pain in the hands and wrists and had a persistently elevated uric acid level. She was relieved after being placed on Allopurinol.® Osteodystrophy or disabling metastatic calcifications have not been observed.

Dialysis-Related Problems

Mild to moderate nausea, vomiting, and headache occurred in about one-fourth of dialysis sessions. This generally responded to symptomatic treatment. Hypotension was infrequent and usually accompanied ultra-filtration when more than five pounds of edema fluid were removed. This was readily corrected by infusion of 300 to 500 milliliters of blood or saline. Temperature elevations (some to 104 degrees) were noted during a few of the dialyses and remitted spontaneously a few hours after conclusion. No satisfactory explanation for this phenomenon has been found.

Cardiac arrhythmias have not been observed, although cardiac monitoring has not been undertaken as a part of routine dialysis. Convulsions occurred on two occasions. One followed the first dialysis on a patient with known idiopathic epilepsy who took diphenylhydantoin and phenobarbital regularly. The dosage of diphenylhydantoin had been increased during the dialysis session and seizures had not recurred. A post-dialysis convulsion, presumed due to salt depletion, occurred also in a patient whose plasma sodium had been inadvertently lowered to 114 milligrams per cent by improper preparation of the dialysate bath.

Muscle cramps were observed frequently and thought to be due to contraction alkalosis with associated decrease in ionizable calcium. This symptom was usually relieved by quinine, small saline infusions, or administration of calcium gluconate.

Arteriovenous shunts lasted from two to eight months with an average lifetime of four months. Clotting occurred on 19 occasions in 43 patient-months of treatment. All patients experienced at least one clotting episode. In 3 patients (Cases 5, 6, and 7) clotting occurred on three or more occasions. These patients were anticoagulated with warfarin. Prothrombin times were maintained in the range of 20 to 40 per cent. No bleeding diatheses were observed during treatment with this drug, although two shunt-clotting episodes occurred during therapy. In most cases the clot was easily dislodged by irrigation with heparinized saline but on three occasions shunt replacement was required.

Bleeding from cannula insertion sites occurred on eight separate occasions. This was usually controlled with a compression dressing. On two occasions, severe intractable bleeding from the arterial cannula necessitated surgical revision. In both cases, the Teflon cannula tip had eroded through the arterial wall.

Shunt infections were observed on six separate occasions. In no case were they severe enough to necessitate removal of the shunt. Prophylactic topical antibiotic ointment was used routinely but when shunt infections were present, systemic antibiotic therapy with erythromycin, ampicillin, or prostaphlin was employed. Staphylococcus aureue, coagulase positive, was cultured from the infected site on three occasions and no growth was obtained in the other instances. Daily shunt care by the patient consisted of washing the surrounding skin with Benzalkalkonium® chloride or Phiso-Hex,® application of antibiotic ointment, and wrapping the arm with sterile gauze dressing. Arm braces described by Gombos, *et al.*[9] were not used.

Therapeutic classification is illustrated in Table 1 and results in Table 2. Complications encountered are summarized in Table 3.

Table 1

Therapeutic Classification According To Gombos[9]

Class	Group
I. Able to work and carry on normal activity; no special care needed.	A. Normal, no complaints. No clinical evidence of disease. B. Able to carry on normal activity; very minor signs or symptoms. C. Normal activity with effort; had signs or symptoms.
II. Unable to work, able to live at home, care for most personal needs; a varying amount of assistance needed.	A. Cared for self; unable to carry on normal activity or to do active work. B. Required occasional assistance but cared for most of his needs. C. Required considerable assistance and frequent medical care.
III. Unable to care for self; required hospital care or equivalent at home.	A. Disabled; required specialized care and assistance. B. Severely disabled, hospitalization mandatory. C. Moribund.

Discussion

The clinical manifestations of uremia and the biochemical abnormalities are in most cases sufficiently correctable to enable otherwise moribund patients to resume productive lives within tolerable limits. The best long term results are obtained in patients found to be highly motivated, intelligent, and cooperative.[2]

In our experience, intermittent hemodialysis, coupled with satisfactory management of dietary and fluid requirements, effectively controlled uremia over a period of fourteen months in six of seven patients with terminal renal failure. These patients have been rehabilitated to varying degrees. All are currently free of severe disability and are able to function adequately as members of a family unit, carrying out most ordinary activities. One patient (Case 2) is a full time college student. Another (Case 4) is a physician who is an intern in another hospital, able to work

TABLE 2

Initial And Present Clinical Status

Patient	Age	Sex	Duration of Uremia (mos.)	Creatinine (ml/min) Clearance	Urine (ml/day) Volume	Duration of Therapy (mos.)	Number of Dialyses	Blood Pressure Initial	Blood Pressure Current	BUN Initial	BUN Current	Therapeutic Classification (d) Initial	Therapeutic Classification (d) Current	Diagnosis	How Established
1	43	M	6	1.3	350	14	117	200/120	140/90	225	100	IIIB	I-B	Chronic Glomerulo-Nephritis	Clinical History
2	21	M	2	1.0	300	12	94	180/110	170/110	135	75	IIIC	I-B	Chronic Glomerulo-Nephritis	Clinica History
3	25	F	3	4.4	100	10(a)	11	170/110	180/120	216	100	IIIB	IIA	Lupus Nephritis	Renal Biopsy
4	25	M	1	1.1	100	6	52	170/110	170/110	117	100	IIIB	I-B	Chronic Glomerulo-Nephritis	Clinical History
5	25	M	2	2.8	200	3	31	180/120	190(b)/120	201	85	IIIB	Died	Arteriolar Nephro-Sclerosis	Autopsy
6	38	F	8	3.3	300	3	16	160/100	160/100	76(c)	120	IIC	I-B	Chronic Pyelo-Nephritis	Renal Biopsy
7	42	F	10	2.2	400	3	27	180/100	140/90	147	110	IIIB	I-B	Diabetic Nephro-Sclerosis	Clinical History

(a) 2 months of dialysis.
(b) At time of death.
(c) After peritoneal dialysis.
(d) According to Gombos.

TABLE 3

Complications Observed In Patients Treated By Periodic Dialysis

Patient	Circulatory Congestion	Edema	Pericarditis, Pericardial Effusion	Arthritis	Neuropathy	Muscle Wasting
1	0	0	0	0	0	0
2	1	1	1	0	0	0
3	2	1	0	1	0	2
4	1	1	0	0	0	1
5	3	1	3	0	0	3
6	0	1	0	0	0	0
7	0	1	0	0	1	0

Key: 0—Not present.
1—Transient problem.
2—Persistent problem.
3—Severe, intractable problem.

on a part time basis. The remainder are currently unemployed but are capable of performing usual housework or gardening chores.

The failure of therapy in Case 5 was considered due mostly to insufficient understanding of, and cooperation with, the requirements of the program.

The maintenance dialysis program described in this report was undertaken in a private community hospital with limited facilities and personnel and unsupported by independent research funds. Economic support has been derived on an individual patient basis. One patient is fully supported by the Veterans Administration. In one case, assistance has been rendered in part by community sources. The remainder of patients utilize personal savings or medical insurance plans to finance their support.

In spite of its limitations and costliness, community hospital dialysis programs such as ours

will help meet the needs of many more patients with chronic renal failure than are now being served by larger centers. Vigorous training programs for home dialysis, using currently available equipment, are also feasible and offer the greatest opportunity for rehabilitation and maintenance of large numbers of patients who require definitive treatment or who are awaiting renal transplantation. Plans are now underway to gain experience in this sphere.

Summary

Seven patients with terminal renal insufficiency were maintained by intermittent hemodialysis at a private community hospital with limited facilities and personnel, and unsupported by independent research funds. Satisfactory results were obtained in six of the patients. It is suggested that such programs, adopted by similar medical centers throughout the country, will help to extend survival of many patients.

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707 South Orange Avenue

Comprehensive Drug Book Now In The Works

A project to develop the most comprehensive reference book on drugs ever produced by the American Medical Association was launched last month. The text will contain authoritative and impartial information on 1,200 to 1,500 drugs — 90 per cent of all nationally advertised single-entity and combination products commonly used by practicing physicians.

The entire departmental staff of 52 persons will be actively involved in gathering and editing information to appear in the reference book, which will take an estimated 18 months to complete. It will contain approximately 1,000 pages of information.

Plans call for the reference book to contain 75 chapters, each of which will be divided into three sections — an introductory statement describing actions and uses, adverse reactions and contraindications of drugs in the specific therapeutic category; individual monograph statements on newer single-entity drugs and complete tabulation of information on older drugs. Extensive, appropriately cross-referenced indexes, including therapeutic indications, also will be included. The tabulated information on older drugs will list names of the individual drugs, their manufacturers; routes of administration and dosage; and give a specific evaluative statement on each product — a key and unique feature of the forthcoming publication.

The reference book is designed to provide the practicing physician with the information he seeks readily and quickly. Members of the Council on Drugs and outside consultants will review each chapter to assure that the information is accurate and current.

STATE ACTIVITIES

Trustees' Minutes

August 20, 1967

A regular meeting of the Board of Trustees was held on August 20, 1967, at the Executive Offices. For your further information, detailed minutes are on file with the Secretary of your component society. A summary of the significant actions follows:

Philadelphia Regional Medical Library . . . Approved the designation of the Chairman of the Committee on Medical Education (Dr. Sherman Garrison of Bridgeton) as our official representative to the Regional Planning Council. This council is assisting the Philadelphia Regional Medical Library Committee and the Library of the College of Physicians of Philadelphia, during the planning and development of a regional medical library under the terms of the Medical Library Assistance Act of 1965.

Resignation of George K. Degnon . . . Accepted the resignation of Mr. George K. Degnon, Executive Assistant to the Executive Director, effective September 8, 1967.

Vote of Confidence . . . Adopted a vote of continued confidence in the administration of the executive offices by the Executive Director, Richard I. Nevin.

Nominations To AMA Councils and Committees . . . Concurred in the action of the Executive Committee in submitting the following nominations for membership on AMA Councils and Committees:

Nomination	Council and/or Committee
Harvey P. Einhorn, M.D. South Orange	Council on Food and Nutrition
Robert S. Garber, M.D. Trenton	Council on Mental Health
Sherman Garrison, M.D. Bridgeton	Committee on Continuing Medical Education
Jack R. Karel, M.D. Hillside	Committee on Disaster Medical Care
Jerome G. Kaufman, M.D. Maplewood	Committee on Medicine and Religion
Joseph A. Lepree, M.D. Elizabeth	Council on Occupational Health
Jesse McCall, M.D. Newton	Committee on Nursing
Fred A. Mettler, M.D. Blairstown	Committee on Medicolegal Problems
Jarvis M. Smith, M.D. Trenton	Committee on Rehabilitation
Francis I. Tomlins, M.D. Ridgewood	Committee on Medical Aspects of Sports

Unincorporated Business Tax . . . Approved the following recommendation (in accordance with the mandate of the 1967 House of Delegates that the Society urge repeal of Chapter 137, 1966 — excise tax on gross receipts of unincorporated businesses):

That MSNJ participate in the proposed joint educational campaign for repeal of the new tax law on the gross income of unincorporated businesses.

This recommendation resulted from a meeting of the Interprofessional Council of Executives (on which MSNJ is represented), where agreement developed to request authorization of respective organizations to participate in such an educational campaign.

AMA Regional Conference On Aging . . . Authorized the Society's cosponsorship, with other area states, of the AMA Regional Conference On Aging to be held, in cooperation with the AMA and the Medical and Chirurgical Faculty of Maryland, in Baltimore on November 2nd and 3rd.

Health Facilities Planning Council . . . Noted the following resolution of the Health Facilities Planning Council of New Jersey, which would seem to deviate from MSNJ's position of encouraging *voluntary* participation in regional planning:

The New Jersey Department of Institutions and Agencies wants to require new and existing hospitals to demonstrate the need for any proposed construction programs and asks that a certificate of necessity for the proposed construction be issued by the Department

only after recommendations have been received from the Regional Health Facilities Planning Council in the region where the construction is proposed and from the Health Facilities Planning Council for New Jersey.

Liberalization of Abortion Law . . . Authorized a survey (and empowered the Executive Committee to agree upon the form to be used) of the entire membership concerning the Society's position on relaxation of laws governing therapeutic abortion.

Joint Meeting With County Presidents . . . Authorized the scheduling of the joint conference of presidents of component societies and the regular October meeting of the Board at the Notre Dame High School in Trenton.

Sub-Committees to the Council on Mental Health . . . Received the recommendation of the Council on Mental Health that the following special committees of the council be established; and referred the outlined functions of such committees to legal counsel for review:

Special Committee on Alcoholism
Special Committee on Drug Addiction
Special Committee on Emotional Disorders of Childhood and Adolescence
Special Committee on Mental Retardation
Special Committee on Seizures

Woman's Auxiliary Program . . . Approved the Woman's Auxiliary Program for 1967-1978, upon recommendation of the Advisory Committee (George W. Rowohlt, M.D., Chairman), as well as the following suggestions of that Committee:

(1) That the attention of component societies be called to those aspects of the program which are related to their activities.

(2) That the relevant councils/committees of MSNJ avail themselves of the cooperation which the Auxiliary stands ready to supply.

(See page 579 of this issue for a complete outline of the program.)

New Jersey Division on Aging Conference . . . Agreed to cosponsor the New Division on Aging Conference (to stimulate local educational programs directed to older consumers), to be held on October 17, 1967 at the Labor Education Center at Rutgers University, and designated Drs. David Eckstein of Trenton and Matthew E. Boylan of Jersey City to represent the Society.

New Jersey Health Careers Service . . . Authorized its usual contribution of $100 for 1967, in support of the program of the New Jersey Health Careers Service.

Ethics Of Drug Prescribing

It is unethical for a physician to be influenced in the prescribing of drugs or devices by his direct or indirect financial interest in a pharmaceutical firm or other supplier. It is immaterial whether the firm manufactures or repackages the products involved.

It is unethical for a physician to own stock or have a direct or indirect financial interest in a firm that uses its relationship with physician-stockholders as a means of inducing or influencing them to prescribe the firm's products. Practicing physicians should divest themselves of any financial interest in firms that use this form of sales promotion. Reputable firms rely upon quality and efficacy to sell their products under competitive circumstances, and not upon appeal to physicians with financial involvements which might influence them in their prescribing.

Prescribing for patients involves more than the designation of drugs or devices which are most likely to prove efficacious in the treatment of a patient. The physician has an ethical responsibility to assure that high quality products will be dispensed to his patient. Obviously, the benefits of the physician's skill are diminished if the patient receives drugs or devices of inferior quality.

Inasmuch as the physician should also be mindful of the cost to his patients of drugs or devices he prescribes, he may properly discuss with patients both quality and cost.

— Opinion of the AMA Judicial Council, March 12, 1967

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

(Listed in order of receipt)

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

INTERNAL MEDICINE — Ronald G. MacClary, M.D., 6 Granada Terrace, Middletown, Rhode Island 02840. University of Michigan, 1958. Board eligible. Group. Available.

Jerome E. Block, M.D., 1601 Greycastle Avenue, Montebello, California. New Jersey College of Medicine, 1964. Solo or associate. Small town. Available July 1968.

Harvey I. Hurwitz, M.D., 33 Coleman Road, West Haven, Connecticut 06516. Boston University Medical School, 1962. Group. Available July 1968.

Alfred M. Derrow, M.D., 555 Wisteria Way. San Rafael, California 94903. Tufts 1962. Subspecialty, Renal Disease. Group. Available July 1968.

Seymour M. Cohen, M.D., 1565-A White Drive, Rantoul, Illinois 61866. University of Pittsburgh School of Medicine, 1962. Board eligible. Sub-specialty, Hematology. Group or partnership. Available July 1968.

OBSTETRICS AND GYNECOLOGY — David M. Margulies, M.D. 69 Euclid Road, Fort Lee, New Jersey. Northwestern University Medical School, 1961. Board certified. Available.

Arthur G. Aneckstein, M.D., 104A Jupiter Street, Sheppard AFB, Texas 76311. Tulane, 1961. Board eligible. Solo, partnership, or association. Available February 1968.

Kenneth E. Bell, M.D., 3175 B Lexington Street, Hill Air Force Base, Utah 84401. University of Buffalo School of Medicine, 1961. Board certified. Available June 1968.

OPHTHALMOLOGY—M. Farooq Anwar, M.D., University Hospital, Birmingham, Alabama 35233. King Edward Medical College, Pakistan, 1960. Full time hospital staff. Available.

PATHOLOGY—Melvin Stahl, M.D., 27 Bradford Road, Natick, Massachusetts 01760. Boston University School of Medicine, 1956. Solo or associate in community hospital. Available November 1967.

PEDIATRICS—Nathan Blinn, M.D., 1514 East Cliveden Street, Philadelphia, Pennsylvania. Jefferson Medical College, 1963. Solo or group. Available July 1968.

Ronald G. Perciaccante, M.D., 93 Beaumont Street, Sheppard AFB, Texas 76311. Georgetown University, 1963. Pediatric group or multispecialty group. Available August 1968.

SURGERY — Lawrence B. Langsam, M.D. 1707 Terry Avenue, Bellevue, Nebraska 68005. Downstate Medical Center, 1960. Board certified. Group or partnership. Available.

A. Allen Badri, M.D., 6315 North Rosebury, Clayton, Missouri 63105. University of Teheran Medical School, 1959. General and plastic. Available.

James M. York, M.D., 741 Mt. Vernon Avenue, Marion, Ohio 43302. Johns Hopkins, 1956. Orthopedic. Available.

Dennis M. Wadler, M.D., 245 East 25th Street, New York, New York 10010. Jefferson, 1961. Board eligible. Associate or group. Available July 1968.

UROLOGY—Alessandro Colalillo, M.D., 750 Mt. Prospect Avenue, Newark, New Jersey. University of Naples, Italy, 1955. Partnership or association with multispecialty group. Available.

Medical Student Leadership In Labor Project

In the summer of 1967, as in many previous summers, migrant workers came into the southern part of our State to help farmers with the crops. However, 1967 was different. A unique health project (largely conceived, planned, and operated by medical students from the New Jersey College of Medicine and Dentistry) made the difference.

Purposes of the pilot were: to provide health, educational, and counseling services to migrant workers; to assist the State Health Department in organizing additional health services for migrants; to compile and analyze health data on migrant workers; to expose medical students to experience in the public health field; and to determine feasibility, potential, and effectiveness of such a medical student project.

Results have excited the medical community and have set the stage for future medical student projects such as a public health program in the ghettos of Newark next summer which is being planned by the college.

"The student project, with the college providing leadership, and the involvement and resources of the state departments has pro-

vided a multiple attack on the migrant health problem. It also has provided an exciting opportunity for the students to gain clinical experience and to get a first-hand view of their profession." said Dr. Robert R. Cadmus, president of the college.

The student-migrant medical program worked this way: the students and Public Health nurses got in touch with farmers employing migrant workers and suggested that they set up clinics on the farms. Our New Jersey farmers were cooperative, and dates were set for evening clinics on the farm. At that time, medical histories of the workers were taken by the students. Later urine, blood, and stool specimens were obtained and tuberculin tests were given. Each worker requiring more attention was given an appointment to report to Burlington County Memorial Hospital several evenings later. There, a meticulous physical examination was given by physicians who are alumni of the college or on the faculty of the college, or by selected members of The Medical Society of New Jersey, who volunteered their services. The medical students made assignments and assisted with the examinations. X-rays were taken when necessary. At a dental clinic, a dental student in the program assisted. Many of these workers had never been to a dentist. They were ophthalmologically screened in a mobile eye unit of the college, staffed by a nurse and two ophthalmologists on the faculty of the New Jersey College of Medicine and Dentistry.

This Migrant Laborer Public Health project was the brainchild of Michael Pozen of Bridgeport, Connecticut, a sophomore at the New Jersey College of Medicine and Dentistry. The State Department of Health made the project possible through the endeavors of Dr. William J. Dougherty, director of its division of preventable diseases.

Members of the student team worked with personnel of the New Jersey State Health Department and the State Departments of Education and of Community Affairs. Mr. Pozen recruited students from other colleges to teach in a school for migrants' children, to interpret, and even to chauffeur migrant workers to the clinics. The result has been a complete package for the migrant and members of his family—classes for the children, recreation programs, and adult education as well as health care.

In addition to Pozen, who directed the project, the students were Eugene Sacks of Oradell; Edward Freedman of Highland Park; Joseph Tarantol of Long Branch; and Burton Speiser of New York. They were joined by a dental student Lonna Kane, a Wellesley alumna from New York City. Pozen recruited Ruth Johr, a Colombian, to teach and to interpret for the Puerto Rican workers; Jane Friedlaender of New York City, a Smith graduate; Phyllis Verri of New Brunswick, a senior at Glassboro; Craig Oettinger of Stamford, Connecticut, a student at New York University Law School; Saul Shapiro of Carmel, New York; Risa Ellovich of Hartford, Connecticut, a senior at Chatham; and Pascal Kaplan of New York City, a student at Harvard Graduate School. These students all participated in the educational, camp, or recreational programs.

Two of the educational staff members, Miss Friedlaender and Mr. Kaplan, have generated community self-service at Holly Gardens, a housing community. They helped to organize a tenant council and establish a recreation program for children. It was a 15-hour work day for all of the students; but the results made it worthwhile. By the end of August, these students had screened half of the 500 migrant workers in Burlington County. The workers seen were from 23 farms.

Through the students' tuberculin testing, it was found that 52 per cent of the migrant workers' population had been exposed to tuberculosis, by contrast with 22 per cent in the general population. Of 107 workers screened for parasites, 60 were found to be infected. Students met with Public Health officials to set up treatment programs for parasitic infestations.

Almost all of the Puerto Rican workers were found to have serious dental problems. Also found was a high incidence of hypertension and of pterygia, probably caused by dust and insecticide spraying. Arrangements were made for ophthalmic surgery on those patients when they return to Puerto Rico.

One of the most rewarding effects was the rapport these students established with the migrant worker community. In addition to gaining their confidence, the students participated in song fests with the workers, played dominoes, and swapped stories in broken English and halting Spanish.

Medical Aspects Of Sports

The team physician and the practitioner who has athletes among his patients will find many topics of interest at the 9th National Conference on the Medical Aspects of Sports, to be held Sunday, November 26 at Houston.

Clinical problems in athletics, sports cardiology, knee injuries, the 1968 Olympics at Mexico City, and specialized sports will be topics of forums and discussions. Morning, afternoon, and evening sessions will be at the Hotel America. Sponsored by the AMA's Committee on the Medical Aspects of Sports, the annual conference is held in conjunction with the AMA's Clinical Convention, November 26 to 29 in Houston. Speakers will include physicians experienced in sports medicine plus widely recognized sports authorities. You will have opportunities after each session to discuss special problems with the speakers. One speaker at the conference will be Eduardo Hay, M.D. of Mexico City, director of the Centro Deportivo Olimpico Mexicano, who will discuss preparations for the 1968 Olympic Games. Another session is devoted to the U.S. Olympic athelete. Others who will make presentations are the U.S. Olympic team physician, Daniel F. Hanley, M.D.; the U.S. Olympic vice-president, Merritt H. Stiles, M.D.; and the executive secretary of the National Athletic Trainers Association, William E. Newell, R.P.T.

The problem of gastroenteritis is both significant and perplexing to athletes who need to be in top shape daily, at home and on the road. Clayton L. Thomas, M.D. will tell you what can be done to minimize this threat. The relationship of cardiac problems to athletic participation will be discussed by Kenneth D. Rose, M.D., who has done research in medical telemetry. He will tell you how the heart actually responds during exercise, as disclosed by telemetric readings.

Nutrition's role in enabling maximum physical performance will be the topic of the Army's authority on the subject, C. Frank Consolazio. "Foolishness and Folklore in Sports" will be the topic of Fred L. Allman, Jr., M.D. of Atlanta, president of the American College of Sports Medicine and orthopedic consultant for University of Georgia varsity teams. Also scheduled is a forum on quackery in sports. This will be led by William M. Fowler, Jr., M.D. who will discuss the reasons for condemning certain drugs used by some healthy athletes.

Richard C. Schneider, M.D., neurosurgical consultant to the University of Michigan, will discuss the medical considerations of returning an athlete to competition following a concussion. Frank L. Raney, Jr., M.D. will talk about rub injuries; Robert E. Anderson, M.D. will report his findings on genito-urinary injuries, as related to sports participation; and Donald J. Erickson, M.D. will discuss the practicality and proper use of injury-treatment devices in the athletic setting. An evening forum will review prevention of knee injuries in sports.

The conference is open to interested physicians and key non-medical athletic personnel. For further information, write to the Committee on the Medical Aspects of Sports, American Medical Association, 535 North Dearborn Street, Chicago, Illinois, 60610.

Renumeration Of House Officers

With respect to the remuneration of residents and interns, here is the current AMA position. This comes from a report of the AMA Council on Medical Education.

It is recommended that the House of Delegates approve the following policy on utilization of private patients in teaching programs; it makes no difference whatever whether the patients are private or non-private if all of the following provisions are met:

1. That patients on private services present the same range of disease as those on public wards and that comparable opportunity exists for responsible participation by the house officer in diagnosis, management, and follow-up.

2. That the attending staff value breadth of viewpoint that comes from time spent in teaching and do not treat teaching as an unwelcome burden inherent in staff privileges.

3. That the teaching attending staff are sufficiently secure in the private doctor-patient relationship to permit house staff responsibility comparable to public wards, and understand in practice the distinction between indoctrination and true learning.

4. That the same critical standards of diagnosis and treatment apply on private and public and ward patients.

The Council recommends the following principles to govern the assignment of professional responsibility of house officers for the care of paying patients.

1. Assignment of responsibility to house officers for the care of patients shall be based on their competence to assume this responsibility.

2. The number of patients assigned to house officers shall be limited by the educational needs of the training program.

3. The care of such patients shall continue to be under the supervision of the attending staff physician, and ultimate responsibility for their care shall remain in his hands.

4. The level of remuneration in all hospitals should be sufficient to support house officers adequately.

5. The medical profession must assume an increasing responsibility for the development of appropriate methods of financial support of the intern and resident. The medical profession should establish basic principles by which hospital attending staffs could be guided in the development of additional funds to supplement, if necessary, those derived from hospital sources.

6. When it is the desire of a hospital professional staff that a special fund be established for the adequate support of house officer training programs, the fund may be developed from a variety of sources, such as endowment income, grants, voluntary contributions, donations, and fund-raising activities.

7. The published provisions for payment under the Medicare Program for services rendered to beneficiaries by interns and residents and by attending physicians supervising interns and residents are compatible with the organization and administration of programs of graduate medical education according to the standards of the American Medical Association. These same principles should apply to regulations governing other third party medical care plans.

8. It is recommended that sources and amount of compensation for house officers should be determined by local agreement, implemented in accordance with state laws and the ethical position of the American Medical Association.

New Directory Of Epilepsy Facilities

There is now available a compact brochure giving a list of all the facilities in the United States for the diagnosis and treatment of epilepsy. You may obtain a copy without cost from the Epilepsy Foundation, 1419 H Street, NW, Washington, D.C. 20005.

Women's Auxiliary Agenda

The Woman's Auxiliary to The Medical Society of New Jersey serves, in a supporting capacity, the programs and purposes of The Medical Society of New Jersey and its component societies. The approved programs of the Woman's Auxiliary — at state and county levels — are formulated and carried out only with the approval of, and in cooperation with, the parent Medical Society. Proposals for Auxiliary participation are weighed and considered in this light. Unless they are consonant with, and are approved by, the Medical Society — at state and local level — they cannot be considered.

The program proposed for 1967-68 is identical with that of 1966-67 except that No. 5 under *Mental Health* was not on last year's agenda.

Official information, correspondence, and records of all offices and committees are kept in the Auxiliary office in Trenton. Official work of the Auxiliary is processed through the staff member of The Medical Society of New Jersey assigned to the Auxiliary. Officers and chairmen do not handle their own assignments from their homes. This affords continuity of projects; details will always be available and the services of the staff member will be most effectively utilized.

Projects and instructions from the national office must be cleared through the state office of the Auxiliary before being transmitted to county level for action.

Communications of all Auxiliary committee chairmen to committees of The Medical Society of New Jersey must first be approved by the president of the Auxiliary.

When the need arises for emergency action on matters having to do with The Medical Society of New Jersey and/or its Woman's Auxiliary, the officer or chairman of a committee desiring emergency action calls the state office of the Auxiliary in Trenton and the request is processed through proper channels.

Programs

AMA-ERF

(1) To raise funds for AMA-ERF through encouraging county projects.

(2) To increase individual contributions.

ANNUAL REPORTS

To compile the annual reports of officers, committee chairmen, and county auxiliaries, for presentation to the membership.

ARCHIVES

(1) To maintain a systematic record of State Auxiliary activities.

(2) To stipulate for county auxiliaries what should be kept as permanent local records.

ARTS AND HOBBIES

(1) To reflect the cultural pursuits and aesthetic accomplishments of physicians and their families through the exhibition of selected items of their creative arts.

(2) At the 1968 Art Exhibit of the State Auxiliary to stress "Paintings and Sculptures by the Physician's Family;" and to bestow merit awards upon successful Auxiliary members.

(3) To invite physicians to contribute exhibits, not in competition for merit awards.

(4) To encourage county chairmen of Arts and Hobbies to form Auxiliary art classes for cultural purposes.

COMMUNITY SERVICE

(1) To cooperate with the Council on Public Relations of The Medical Society of New Jersey in any project or projects it may suggest.

(2) To cooperate with county medical societies in making available to approved groups various health films from the AMA or other appropriate sources, and to make available acceptable speakers on health subjects.

(3) To cooperate with the Committee on Health Careers.

(4) To encourage Auxiliary members to assist with programs of health organizations approved by the Medical Society, such as: Heart, Tuberculosis, Cancer, Red Cross, Hospital Auxiliaries, and the like.

(5) To continue educational programs for Auxiliary members, to maintain an informed auxiliary — collectively and individually —on health subjects and the medical profession.

CONFERENCE

To instruct and indoctrinate county presidents and county chairmen.

CONVENTION

(1) To make arrangements for the annual meeting.

(2) To sponsor an Art Exhibit for Auxiliary members and members of The Medical Society of New Jersey.

CREDENTIALS

(1) To verify the credentials of the delegates and alternates to the Annual Meeting.

(2) To keep a record of attendance at Executive Board meetings and annual conference and to make reports thereon.

DISASTER PREPAREDNESS

(1) To encourage members to acquaint themselves with their local civil defense programs and to take an active part in these programs.

(2) To support the health mobilization project and to promote the medical self-help program.

(3) To recommend literature on civil defense efforts to the membership — with approval of the county medical society. The first suggested reading could be the pamphlet entitled *Fallout Protection, What to Know and Do About Nuclear Attack,* distributed by the Post Office.

FINANCE

To propose a yearly budget, supervise expenditures, and approve expense vouchers.

HEALTH CAREERS

(1) To collect and distribute materials on health careers for high school graduates.

(2) To make the *Health Careers Guidebook* available to high school guidance directors.

(3) To encourage guidance directors to make health careers' information available to interested students.

(4) To continue to promote Future Nurses' Clubs in high schools; and to encourage nurses' scholarships, and also scholarships in the allied health fields.

(5) To encourage county chairmen (with the approval of their component medical societies) to plan at least one program during the year to which are invited high school students, educators, hospital personnel, and representatives of health organizations.

(6) To request advice of component societies as to whether Future Physicians' Clubs in high schools should be encouraged.

(7) To maintain a list of scholarships available in the state for health careers.

HISTORIAN

To compile a comprehensive record of the year's activities.

HOSPITALITY

To arrange the amenities of Board meetings.

INTERNATIONAL HEALTH ACTIVITIES

Program of medical relief to promote international understanding. Collection and shipment to designated areas of books, medical samples, linen, and equipment.

JERSEY MEDICAL POLITICAL ACTION COMMITTEE

Promote and support JEMPAC.

LEGISLATION

(1) To distribute to county legislative chairmen such material as may be referred by the Council on Legislation of MSNJ.

(2) To encourage telephone committees, at the county level, to call individual Auxiliary members when urgent activity is necessary.

(3) To urge county legislative chairmen to make a full report on legislative actviities at each county Auxiliary meeting, to keep members fully informed.

(4) To cooperate with the Community Service Committee of the State Auxiliary in supplying material for use in its public programs.

(5) To urge county chairmen to offer assistance to their county medical societies on participation of the all-important program to preserve the freedom of medicine and the high standards of medical care.

MEDICAL STUDENT LOAN FUND

(1) To raise funds for the Medical Student Loan Fund of MSNJ and to cooperate with the Committee of MSNJ upon request.

(2) To encourage auxiliary members to make individual and group contributions; and to urge them to make and solicit donations to the Fund to honor the living and to commemorate the dead.

MEDICINE AND RELIGION

(1) The Chairman of the Committee on Medicine and Religion of the Woman's Auxiliary to MSNJ will be available to assist the Committee on Medicine and Religion of MSNJ in any endeavors at state level.

(2) Component societies of MSNJ have been asked to establish committees and to encourage the establishment of an operating Committee on Medicine and Religion in every hospital in their counties.

(3) In each county in which the component medical society is proceeding upon the foregoing request, a chairman on Medicine and Religion should be designated by the Auxiliary to carry out assignments or in other ways to cooperate with the Committee on Medicine and Religion of the county medical society.

MENTAL HEALTH

(1) To cooperate with the Council on Mental Health of The Medical Society of New Jersey.

(2) To know our local mental health facilities.

(3) To encourage every county auxiliary to devote one meeting a year to a mental health program and/or a visit to a nearby mental hospital, as approved by the county medical society.

(4) To approve programs on emotional problems of children.

(5) To encourage volunteer work in state hospitals, local mental health facilities, or psychiatric units in general hospitals.

NEWSLETTER

To edit and publish up to ten issues of *The Shingle*.

NOMINATIONS

To prepare a panel of nominees for elected offices, as provided in our Constitution.

ORGANIZATION AND MEMBERSHIP

(1) To establish an auxiliary in Sussex County with the approval and cooperation of the county medical society.

(2) To encourage wives of physician-members of MSNJ to join their county auxiliaries; to encourage eligible members of doctors' families to join.

PARLIAMENTARIAN

To advise the president on all questions of parliamentary procedure.

PRESS AND PUBLICITY

To send meeting announcements and reports of auxiliary activities to county press and publicity chairmen.

PROGRAM

(1) In collaboration with the Executive Board, to prepare programs for meetings of that body in furtherance of goals or priority projects named by the President.

(2) To distribute to county auxiliary presidents and program chairmen State approved packaged program material, which became available in June after the annual meeting of the Woman's Auxiliary to the AMA.

(3) To formulate and distribute specifications for the county activity posters which are to be submitted and judged at the annual meeting of the Woman's Auxiliary to MSNJ.

(4) To encourage all county auxiliaries to prepare program yearbooks for distribution to members.

(5) In conjunction with county medical society committees and other auxiliary chairmen, to encourage study groups to further understanding and sociability.

RESOLUTIONS

To draw up resolutions at the request of the Auxiliary.

REVISIONS

To revise the Constitution and Bylaws, as required. Proposed revisions will be submitted to the Advisory Committee of MSNJ for consideration before action is taken.

SAFETY

(1) To communicate with county safety chairmen in order to achieve cooperation in safety programs and efforts.

(2) To request space for safety items and ideas in *The Shingle*.

(3) To cooperate with the New Jersey State Safety Council and its county units.

WIDOWS AND ORPHANS

(1) To encourage membership in the Society for the Relief of Widows and Orphans of Medical Men of New Jersey.

(2) To encourage the establishment of a committee on widows and orphans by each county auxiliary. To advance this program with the approval and assistance of the component medical society.

(3) To supply information and speakers to county auxiliaries in furtherance of this program.

Decontamination Study

An eight-page illustrated booklet, *Surface and Air Decontamination: An Improved Spraying Technic,* which describes test methods and results of an environmental decontamination study at the New York Hospital – Cornell Medical Center, is now available. The booklet was prepared in connection with a scientific exhibit sponsored by the Center at the 14th national congress of the Association of Operating Room Nurses in San Diego, California, February 19 to 23. Copies may be obtained free by writing Charles K. McSherry, M.D., New York Hospital – Cornell Medical Center, 525 East 68th Street, New York, New York 10021.

ANNOUNCEMENTS

A Postmortem On Postmortems

An unusual symposium is scheduled for 3 p.m., Saturday, October 21, on the role of the autopsy in modern medicine. The meeting will be held at the Academy of Medicine, Fifth Avenue at 103rd Street, New York City, under the auspices of the Foundation for Medical Knowledge.

One speaker, R. D. Teare, M.D., is Professor of Medicine at the University of London in England. He will speak on "The Scotland Yard Autopsy." Dr. Alfred Angrist of Albert Einstein Medical College will tell you how "to break the autopsy barrier." Papers on research and the autopsy will be given by Edward Gall, M.D., University of Cincinnati, and J. F. McManus, M.D. of the American Society for Experimental Biology. The final speaker will be Milton Helpern, M.D., who is New York's Chief Medical Examiner. No registration fee is required, but send a card to the Foundation For Advancement Of Medical Knowledge, 21 East 90th Street, New York City 10028, to tell them to expect you.

Psychiatry For The General Practitioner

Temple University's second Annual Institute on "Psychiatry for the General Practitioner" will be held November 4th and 5th at the Marriott Motor Hotel on City Line Avenue in Philadelphia. The conference is approved for thirteen hours of AAGP credits.

Formal presentations, followed by discussion, will be offered by members of the faculties of the medical schools of Temple University and University of Pennsylvania. Round table discussion groups will consider drug addiction, alcoholism, marital problems, the developing child, chronic illness, and many other subjects.

The $20 fee includes two luncheons. Wives are invited to attend the luncheon on Sunday ($4), when Dr. Margaret Mead, Curator of Ethnology at the American Museum of Natural History, will ask whether "The General Practitioner Can Transcend His Culture?"

For further information write to the Temple University Health Sciences Center, Department of Psychiatry, 3400 North Broad Street, Philadelphia 19140, attention of the Administrative Assistant, C. J. Roddy.

Courses In New York City

Columbia University announces the following graduate courses for MD's. Write to Melvin D. Yahr, M.D., College of Physicians and Surgeons, 630 West 168 Street, New York 10032. Dr. Yahr is the Associate Dean concerned with these programs.

Clinical Electrocardiography, M. I. Ferrer. Eight days, 12 noon, Nov. 15, 22, 29, 30 and Dec. 6, 7, 13, 14, 1967. Fee: $50.

Clinical Hematology, J. F. Bertles, J. M. Goldstone and F. A. Flatow. Twelve Tuesdays, 3-5, Oct. 3-Dec. 19, 1967. (St. Luke's Hospital Center) Fee is $75.

Clinical Cardiology, E. P. Childs, A. L. L. Bell and M. J. Schwartz. Fifteen Saturdays, 9:30-12:30, Sept. 9-Dec. 16, 1967, Repeated Jan. 6-Apr. 20, 1968 (St. Luke's Hospital Center) Fee: $125.

Gynecologic Endocrinology, J. Birnbaum. Five Thursdays, 3-5, Oct. 19-Nov. 16, 1967. (Brookdale Hospital Center) Fee: $50.

Pediatric Cardiology, R. J. Golinko and C. B. Ripstein. Six Thursdays, 3-4:30, Mar. 7-Apr. 11, 1968. (Brookdale Hospital Center) Fee: $50.

Symposia For The Family Physician, Stanley Stark and Staff of Brookdale Hospital Center. Twelve alternate Fridays, 9-10:30, Oct. 20, 1967-Apr. 12, 1968. Fee: $125.

Basic Hypnosis, Herbert Spiegel. Seven Saturdays, 10-1 and 2-5, Oct. 7-Nov. 18, 1967. Fee: $175.

Radiologic Physics, Paul Goodwin. Fifteen weeks, Tuesdays and Thursdays, 5-6, Oct. 3, 1967-Feb. 1, 1968. Fee: $50.

Radiology of Bones and Joints, Meyer Alpert. Twelve Thursdays, 7-8:30 p.m. Sept. 21-Dec. 21, 1967. Fee: $75.

Physics of Radiology, E. E. Stickley, S. Hilal, and W. Seaman. Eight weeks, Tuesdays and Thursdays, 5-6, Feb. 6-Mar. 28, 1968. Fee: $75.

Nuclear Medicine, P. M. Johnson. Nine weeks, Tuesdays and Thursdays, 1-2, Apr. 4-June 6, 1968. Fee: $75.

Diagnostic Roentgenology of the Gastrointestinal Tract, I. Bluth. Fourteen Tuesdays, 3:30-4:30, Sept. 12-Dec. 12, 1967. Fee: $150.

Advances in Colon Surgery, C. B. Ripstein, Five Thursdays, 3-5, Nov. 2-Dec. 7, 1967. Fee: $50.

Urologic Pathology, M. M. Melicow and M. Tannenbaum. Eleven days, Mondays and Thursdays, 3-6:30, Jan. 4-Feb. 5. 1968. Fee: $150.

Program For Practitioner At AMA Houston Convention

A scientific program, tailored for the M.D. in practice, will be featured at the AMA Clinical Convention in Houston, November 26 to 29. Of special interest are courses in oncology, fluid and electrolyte balance, cardiovascular disease, obstetrics, and gynecology. Each course consists of three half-day sessions led by a star-studded faculty.

Scientific and industrial exhibits and all scientific meetings will be held in Houston's new Astro Hall, a part of the Astrodome complex. Topics at the general scientific sessions include: aerospace medicine, antibiotics, arthritis, cancer, cardiovascular medicine, cardiovascular surgery, dermatology, endocrinology, gastroenterology, general surgery, geriatrics, obstetrics, urology, gynecology, ophthalmology, otolaryngology, pediatrics, and psychiatry. There also will be a session on the legal and social problems now faced by the physician. Breakfast roundtables will discuss antibiotics, the moral and ethical aspects of caring for the dying patient, cerebrovascular insufficiency, and "adolescence"—the age of rebellion.

Live color television broadcasts of surgery and discussions from Houston's Hermann Hospital will be seen on a large screen in Astro Hall. Medical motion pictures will include four premier showings, plus several films that were well received at the convention last June.

Seminar On Disability Determinations

On Wednesday, November 29, 1967, starting at 9 a.m. (under the sponsorship of the New Jersey Rehabilitation Commission, Disability Determinations Service) there will be a one day seminar entitled, "The Doctor and the Disability Decision." The meeting will be held at the Rutger's Labor Education Center, Ryders Lane, New Brunswick.

Physicians will have an opportunity to learn disability evaluations, including their own role in these decisions. Special attention will be given to disabilities in the fields of orthopedics, cardio-pulmonary diseases, psychiatric disorders, special senses, and neurologic conditions. Doctors having special problems with disability determinations may submit questions in advance to Jarvis M. Smith, M.D., Medical Director, New Jersey Rehabilitation Commission, Labor and Industry Building, Trenton, 08625; these questions will be discussed at the meeting.

Stroke: A Program Of Bedside Teaching

The first twenty physicians to apply will be accepted for a two-day course on the management of stroke. This will not be in the form of didactic lectures. The student-physician will be at the bedside and participate in supervised management of the patient. Videotapes and films will supplement this bedside learning. Tuition is $50. For more information, write to Thomas Anderson, M.D., Rehabilitation Institute, 1800 Chicago Avenue, Minneapolis, Minnesota 55404. The next course will be in Minneapolis in January 1968.

New Jersey Society For Plastic Surgery

A New Jersey Society of Plastic and Reconstuctive Surgery has just been formed. Its president is Jerome Gelb, M.D. of Irvington. The vice-president is William C. Conroy, M.D. of Montclair. For more details, write to the secretary of the New Jersey Society of Plastic and Reconstructive Surgery, Dr. Edward N. Ludin, 411 Cooper Street, Camden 08102.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1967

October

11 **Essex County Medical Society**
With Women's Auxiliary
Hotel Suburban, East Orange
"Narcotics and the Teenager"

11 **Ocean County Medical Society**

12 **Burlington County Medical Society**
Scientific Business

17 **Warren County Medical Society**

17 **The Academy of Medicine of New Jersey — Section on Dentistry**
"Factors Affecting Local Anesthesia — An Experimental Approach"

18 **Passaic County Medical Society**

18 **New Jersey Obstetrical and Gynecological Society**
Holy Name Hospital, Teaneck

19 **Morris County Medical Society**

19 **The Academy of Medicine of New Jersey — Section on Urology**
Essex House, Newark
"Radiotherapy in Bladder and Prostate Cancer"

19 **The Academy of Medicine of New Jersey**
Warner-Lambert, Morris Plains
Symposium — "Intensive Care of the Cardiac"

24 **The Academy of Medicine of New Jersey and Rutgers Medical School**
Rutgers, the State University, New Brunswick
Immunology Workshop

25 **Camden County Tuberculosis and Health Association**
Woodbury Country Club, Woodbury
Conference — "New Concepts in TB and RD"

November

2 **Atlantic and Camden County Medical Societies and Heart Associations, and Lederle Laboratories**
Cherry Hill
Medical Symposium

2 **New Jersey State Hospital**
Marlboro
Symposium — "Can Community Mental Health Centers and Mental Health Hospitals Coexist?"

4 **Health and Welfare Council, Bergen County Medical Society; Bar Association; Bergen County School Superintendents Association**
The Chalet, Roselle Park
"The Community's Responsibility for Unwed Parents and the Children"

4-5 **New Jersey Society of Internal Medicine and College of Physicians**
Haddon Hall, Atlantic City

7 **Hudson County Medical Society**

8 **Ocean County Medical Society**

8 **The Academy of Medicine of New Jersey**
Atlantic City Hospital
"Intensive Care of the Cardiac"

9 **Essex County Medical Society**
Hotel Suburban, East Orange
"Why is Newark Being Depleted of Doctors?"

14 **Bergen County Medical Society**

14 **New Jersey Dermatological Society**
Newark Beth Israel Hospital
Clinical Meeting

15 **New Jersey State Dental Society**
Semi-Annual Session

15 **Middlesex County Medical Society**

15 **The Academy of Medicine of New Jersey**
Newark City Hospital
Workshop on Cytogenetics

16 **Morris County Medical Society**

16 **The Academy of Medicine of New Jersey**
Warner-Lambert, Morris Plains
Symposium — "Oral Contraceptives"

16 **6th Annual Obstetrical and Gynecological Seminar**
St. Peter's General Hospital
New Brunswick

21 **Passaic County Medical Society**

22 **Monmouth County Medical Society**

22 **The Academy of Medicine of New Jersey**
Newark City Hospital
Workshop in Cytogenetics and Inborn Errors of Metabolism

28 **Cape May County Medical Society**

December

2 **New Jersey Chapter, American College of Surgeons**
Annual Meeting

5 **Hudson County Medical Society**

6 **The Academy of Medicine of New Jersey**
Robert Treat Hotel, Newark
"Antibiotic Induced Toxic and Hypersensitivity Reactions"

6-7 **The Academy of Medicine of New Jersey**
Newark City Hospital
Workshop on Culdoscopy

12 **Bergen County Medical Society**

12 **Cumberland County Medical Society**

13 **Ocean County Medical Society**

13 **The Academy of Medicine of New Jersey**
Cherry Hill Inn
Symposium on Trauma

14 **Burlington County Medical Society**
Scientific/Business

20 **Middlesex County Medical Society**

21 **Morris County Medical Society**

1968

January

9 **Bergen County Medical Society**

10 **Camden County Medical Society**

11 **Essex County Medical Society**

18 **Morris County Medical Society**

24 **Saint Elizabeth Hospital**
Elizabeth
"Family Life"

30 **Cape May County Medical Society**

31 **Essex County Heart Association and Academy of Medicine**
Mutual Benefit Life Insurance Company, Newark
17th Annual Heart Seminar

February

13 **Bergen County Medical Society**

15 **Morris County Medical Society**

21 **The Academy of Medicine of New Jersey**
Robert Treat Hotel, Newark
Pediatric Symposium

March

6 **Camden County Medical Society**

6-9 **New Jersey Academy of General Practice**
Atlantic City

7-8 **The Academy of Medicine of New Jersey**
Newark City Hospital
Workshop on Culdoscopy

12 **Bergen County Medical Society**

12 **Essex County Medical Society**
Hotel Suburban, East Orange
"What Can An Office Consultant Do For You?"

13 **The Academy of Medicine of New Jersey**
Mountainside Hospital, Montclair
Symposium on Supraventricular Arrhythmias

21 **Morris County Medical Society**

26 **Cape May County Medical Society**

LETTER TO THE JOURNAL

Reviving The GP

I am afraid I quite agree with the writer of the JOURNAL editorial (July '67) entitled, "Rural GP: A Vanishing Beeed?". I would however, go a step further. The GP is a vanishing breed not only in rural but in urban areas as well. Their diminution in numbers is an acute situation, state-wide. Remember, New Jersey had no medical school until twelve years ago!

The last line of this editorial reads . . . "If we doctors don't find the answer (to the shortage) some other group will try." Clearly, it has been the responsibility of the Medical Society to resolve this problem.

Both The Medical Society of New Jersey and the American Medical Association have recognized the seriousness of the shortage. But the sad truth is that even as the need is documented (three national studies last year), the number of physicians electing to enter general practice goes down. Question: How could a student in either of our medical schools decide on general practice? In a vacuum? Neither school has such a department!

Concerned with the shortage, and disappointed with a lack of impetus (provided neither by the Society nor the medical educators), the Trustees of the New Jersey Academy of General Practice turned their attention to the legislature.

Twice, Assembly bills charging both medical schools with the responsibility of training practicing physicians passed the Assembly unanimously. (A-109 in 1966 and A-280 this year.) Both bills died in the Senate Education Committee. The stranglehold seems obvious and the question persists. What individual or group of individuals, if not our own Society, is going to see itself as ultimately responsible for the health and well-being of the people of New Jersey?

Lamenting the fact that medical schools have failed to meet this problem, Dr. Richard M. Magraw, Professor of Medicine at the University of Minnesota, said, "Today's faculty is often so far removed from medical practice and care as to be unable to make judgements on the basis of first-hand experience. Because of this, they have difficulty in deciding about the needs of educating students in family practice or developing a course of study leading to the new primary physician. To make a new and significantly different educational program succeed today, joint action is required by practicing physicians, the public, and medical education institutions."

I submit, gentlemen, that the time is now for vigorous and whole-hearted support of A-280 which will charge our two tax-supported medical schools with the responsibility of producing practicing family physicians, and discharging at the same time our moral responsibility to the people of New Jersey.

Edward A. Schauer, M.D. President
Louis Kosminsky, M.D., Past-president
New Jersey Academy of General Practice

OBITUARIES

Dr. Lawrence G. Brown

One of our State's senior physicians, Dr. Lawrence G. Brown of Elizabeth, died on August 14, 1967 at the age of 81. Born in South Carolina during the first administration of Grover Cleveland, he earned his M.D. at Howard in 1914. With the establishment of the NAACP, Dr. Brown became the founder of its Elizabeth branch, serving at one time or another in all its offices. He was a doughty champion of the American Negro long before that had become fashionable. He was the first Negro physician to serve in this Society's House of Delegates. Dr. Brown received countless awards. He was the only Union County physician to receive the Bnai Brith Award. He was the designer of the "Double-Bell stethoscope," the first president of the Union County Urban League, and the laureate of the Simberloff Award "for advancing the cause of human relations." Dr. Brown was a general practitioner on the staffs of both Alexian Brothers and St. Elizabeth Hospitals.

Dr. Harry Noah Comando

One of the pominent figures in the New Jersey surgical field, and more recently in the field of Blue Shield—Professional Relations, Dr. Harry N. Comando died on July 2, 1967 at the age of 76. Dr. Comando received his M.D. at the old Medico-Chirurgical College of Philadelphia in 1912. He was essentially a surgeon, a FACS, a Diplomate in Surgery, and an early member of the New Jersey Society of Surgeons; and he had been a chief of surgery at Newark Beth Israel Hospital for many years. In addition, he was consulting surgeon at several other hospitals in the Essex County area. After his retirement from active surgical practice, Dr. Comando assumed the position with Blue Shield which he held up to the time of his death.

Dr. William M. Fliegel

One of Bergen County's senior practitioners died on June 1, 1967 at the age of 68. Dr. Fliegel was a native of Pennsylvania, receiving his M.D. at Jefferson Medical College in 1928. He interned in Bergen County and decided to remain in this State. He was a general practitioner in the town of Maywood and affiliated with the Hackensack Hospital. Dr. Fliegel retired in 1964, becoming an Emeritus Member from Bergen County.

Dr. Benjamin A. Furman

Dr. Benjamin A. Furman, an emeritus member of our Essex County Medical Society, died on June 30, 1967. Dr. Furman, a Princeton alumnus (BA 1906) received his M.D. from Columbia University's College of Physicians and Surgeons in 1910. He interned at the New York Presbyterian Hospital and was identified with the Newark Presbyterian Hospital during most of his professional life. He was a Fellow of the American College of Surgeons, and was active in our New Jersey Academy of Medicine. Dr. Furman was 84 years old at the time of his death.

Dr. Joseph J. Labow

Dr. Joseph J. Labow, one of Union County's leading internists, died on August 10, 1967. Born in Elizabeth, New Jersey in 1904, he received his M.D. at Bellevue in 1927. He was affiliated with all three hospitals in Elizabeth; and at the Elizabeth General Hospital, he was a senior attending. He was a Board diplomate in internal medicine, a Fellow of the American College of Physicians, and active in the affairs of the American Diabetes Association.

Dr. Otto G. Matheke, Sr.

One of the grand old men of New Jersey medicine, Dr. Otto G. Matheke, Sr., died on June 16, 1967 at the age of 85. Dr. Matheke earned his M.D. at the Baltimore Medical

College in 1908. After several decades of general practice, he limited his work to surgery and became attending surgeon at St. Michael's and Presbyterian Hospitals in Newark; and he served as surgical consultant to many other hospitals in that area. He was an Emeritus Member of this Society, and in 1958 was the laureate of one of our Golden Merit Awards. Dr. Matheke was, in past years, very active in the affairs of the Essex County Medical Society and the New Jersey Society of Surgeons.

Dr. Charles Fisher Trautwein

Dr. Charles F. Trautwein, one of the senior members of the Essex County Medical Society, died on June 3, 1967. Born in 1898, Dr. Trautwein received his M.D. at the Long Island College of Medicine in 1931. He was active in medical affairs in the West Essex area, and practiced for many decades in Irvington. Before his retirement he was affiliated with the St. Barnabas and Irvington General Hospitals.

Dr. Nicholas Vostrosablin

At the age of 87, Dr. Nicholas Vostrosablin died at his home in Jersey City on July 21, 1967. Born in 1880, he received his M.D. in 1904 from the medical school of the University of St. Petersburg—as it was then called. A general practitioner with special interest in internal medicine, he served the people of Hudson County for a half-century. He was on th staff of the St. Francis Hospital in Jersey City.

BOOK REVIEWS

Learning Medical Terminology Step By Step. Clara G. Young and J. D. Berger, M.D. St. Louis, 1967, Mosby. Pp. 327. 42 illustrations. ($7.50)

More and more nonphysicians are becoming involved in understanding medical terms and in preparing medical reports. This book presents medical terminology in an orderly fashion. It first acquaints the reader with the prefixes, suffixes, and root forms (mostly Latin and Greek) out of which the technical medical vocabulary is built. It then goes into the structure and function of each body system, showing how to spell and pronounce the commoner medical words applicable to that body system. Then a number of verbatim hospital records and autopsy reports are given with a challenge to the reader to understand each of the medical terms found there, and suggestions as to how to track down these meanings. A section on filling out insurance form claims is included. It is, perhaps, somewhat overpriced at $7.50. Apart from this, it is an excellent guide for the medical secretary, technician, attorney, and insurance adjuster. In addition to the introductory material and appendices, there are fourteen chapters of text. Any one who studies these carefully, one chapter a week, will, by the fourteenth week, have acquired a substantial mastery of medical terminology.

Ulysses S. Frank, M.D.

Alcoholism. International Psychiatry Clinics. Edited by Jack H. Mendelson, M.D. Boston, 1966, Little, Brown. Pp. 260. ($4.65 or $18.50 for the four volumes of the 1966 Clinics series)

It seems that man, on the verge of sending a mouse to the moon (for a billion dollars or so) is unable to cure the alcoholic. We already have many five-foot shelves of books on the subject, and here is one more. Philip Solomon has a good chapter on treatment; but apart from this 30-page section, there is very little in this volume which will tell the physician what he can do about his alcoholic patient. It sometimes seems as if one of our difficulties is that we have talked so much about alcoholism being a disease rather than a crime, that we have convinced the alcoholic that none of this is his fault. He is taught to see himself as a passive victim of a mysterious disease. Thus, he has no further responsibility: it's up to the doctor to cure him. In general, this is the approach in most of the twelve chapters in the book. The text includes a discussion of police and court aspects, many paragraphs on what one's attitude toward the alcoholic should be, suggestions for research, an analysis of community resources (especially in Boston), an appraisal of alcoholic women, and a discussion of managing the acute drunk. This chapter, one might expect, would suggest the actual treatment program in terms of medication and dosage. "I have avoided going into details of specific medication," explains the author, "because there are so many useful drugs available."

Taken as a whole, the book offers a multi-facetted approach to a complex problem. If this text does not give the practitioner many practical answers, it does, at least, raise a lot of questions.

Henry A. Davidson, M.D.

Psychiatry In The General Hospital. International Psychiatry Clinics. Edited by Bernard Bandler, M.D. Boston, 1966, Little Brown. Pp. 275. ($4.65 or $18.50 for the four volumes of the 1966 Clinic series).

For twenty years the Boston University School of Medicine has operated its general hospital psychiatric service. It has distinguished itself not only for its teaching of medical students and psychiatric residents, but also because a high proportion of its alumni have found careers in the public hospital system. The story of this enterprise is detailed in this volume, the fall 1966 issue of *International Psychiatry Clinics*. The text covers the way in which this program functioned in teaching medical students, the contributions it made to pediatric residents and house officers in other hospital services, and of course, its method of training psychiatric residents. The way the service developed is described in a chapter by the editor. Admissions procedures, diagnostic methods, research activities, the child psychiatry service, the role of the psychologist, and the way in which Boston University went about setting up a community mental health center are all discussed.

The sharp focus on Boston University and the personnel who pioneered in this program give the book a pleasant and homey quality, though it also raises some question about the transferrability of the experience to other settings. How many patients recovered within this framework is not spelled out, but since the service had a 90-day maximum stay, one must suppose that those who didn't get well, went on the state hospitals.

FELIX A. UCKO, M.D.

Emergency Psychiatry And Brief Therapy. International Psychiatry Clinics. Edited by G. J. Wayne, M.D. and R. R. Koegler, M.D. Boston, 1966, Little Brown. Pp 217. ($4.65; or $18.50 for the four volumes of the 1966 Clinic series)

The snail-like pace of psychiatric treatment has been one of the complaints of patients and nonpsychiatric physicians alike. The editors of this volume and its 13 contributors (all from Los Angeles) suggest that long treatment is not necessarily better than short; that sometimes brief contact therapy (BCT) is superior to the prolonged. often interminable contacts of old-fashioned analysis; that many psychiatric emergencies require swift care to which private practitioners of psychiatry are rarely geared; and that traditional long-contact procedures are too expensive for most Americans. This volume, in the *International Psychiatry Clinics* series, examines short and emergency treatment methods — allowing the patient to talk it out, providing privacy, administering drugs, offering electroshock and similar therapies, getting patients actively to participate in these programs, assuring consistent follow-up, convening family conferences, providing recreational opportunities, and furnishng emotional support. There is even discussion of therapy without patients — that is treating a patient indirectly through an intermediary, such as a social worker, who meets with the psychiatrist, gives a case report and listens to his suggestions.

Several Los Angeles experiments in hrief and emergency therapy are detailed, including surprisingly successful work with skid-row alcoholics, intervention in suicide crises, handling psychosomatic emergencies, managing the emotional problems of injury and medical disease, and effecting immediate relief of psychiatric symptoms.

The 16 chapters are somewhat uneven in quality, with a paucity of practical pointers and rather extensive treatment of the philosophical and academic aspects of each problem. However, the text will be valuable to psychiatrists at the growth edge of this new trend, and will be interesting to all physicians who want to know what's new in the care of the emotionally sick.

ABRAHAM LEFF, M.D.

The Clinical Interpretation Of Psychologic Tests. International Psychiatry Clinics. Edited by James J. Muller, Ph.D. Boston, 1966, Little, Brown. Pp. 292. (4.65 or $18.50 for the four volumes of the 1966 Clinic series)

Most physicians know that psychologists have at their disposal an interesting warehouse of tests. In this volume, ten psychologists and one psychiatrist contribute essays on many aspects of personality and intelligence testing. In Dr. Muller's highly readable introduction, there is a useful explanation of testing technics, of the limitations on testing, of the significance of various surrounding conditions, and of the ways in which tests are standardized. Bernard C. Glueck, the one psychiatrist author, has an arresting chapter on the use of computers in getting scores and clinically interpreting them. There are sections on the use of tests for assessing motivation, mood, intelligence, aptitudes, self-control, and general personality. Special attention is given to the testing problems of childhood and adolescence. The related area of intra-family reactions is reviewed in another chapter, which shows how projective tests can help clarify these reactions. Several of the sections furnish good historical perspective, and the work as a whole is an effort to keep psychologic measurement methods within the area of interprofessional dialogue. There is no attempt to oversell testing, and many of the authors caution against any efforts to see their tests as magical diagnostic instrments. On the whole, a well rounded, well-balanced book.

WILLIAM SCHRAM, M.D.

A Manual Of Tropical Medicine. 4th Ed. George W. Hunter, III, Ph.D., Col. U.S.A. (Ret.); William W. Frye, Ph.D., M.D., P. Clyde Swartzwelder, Ph.D. Philadelphia, 1966, Saunders. Pp. 931. Illustrated.

In this one volume the nutritional, viral, rickettsial, hacterial, fungal, spirochaetal, protozoan, helminth, and arthropod produced diseases of the warm climates are discussed in detail by forty experts. For the busy physician, interested primarily in diagnosis and treatment, there are good clinical descriptions, methods for laboratory diagnosis, and up-to-date specific directions for therapy. For those who desire a broader view, there is extensive biologic and epidemiologic material. The manv illustrations are relevant both clinically and biologically. The latter makes this book of value to laboratory workers. An extensive bibliography at the end of each section gives an opportunity for study in greater depth.

The first edition of this book was prepared to meet the needs of the Armed Forces. It still meets their need admirably. It is invaluable for workers abroad as well as physicians at home, where a surprising number of patients with the diseases discussed in this volume will be found.

This is probably the most authoritative, up-to-date, and comprehensive book in its field.

HAROLD W. BROWN, M.D.

Thymus: Experimental and Clinical Studies. Ciba Foundation Symposium. Edited by G. E. W. Wolstenholme and Ruth Porter. Pp. 538. Boston, 1966, Little, Brown. ($15.00)

The symposium was arranged in honor of its chairman, Sir Macfarlane Burnet, whose major contributions in immunology have led to a world reputation. Papers by outstanding immunobiologists summarize views of thymic immunologic functions as of 1965. The areas covered include the structure and development of the thymus, immunologic functions of the lymphocyte, the role of the thymus in cellular and humoral immunity and in carcinogenesis, and the relationships of the thymus to autoimmune diseases.

A number of contributions deserve particular comment. Convincing evidence is presented by Clark that thymic cells secrete humoral factors regulating immunogenesis. Dameshek theorizes on the genesis of leukemic lymphoma and multiple myeloma as related to lymphocyte proliferation. The relationship of the thymus to autoimmune diseases is discussed capably by Shauss, von der Veld, and Mackay. This symposium emphaizes that the thymus is the center of lymphoid cell differentiation and the main source for new immune patterns, and that several hormonal factors are associated with the thymus.

The book is important for all interested in immunobiology. It is oriented to basic research, and therefore not a book for the clinician's library.

Richard L. Fogel, M.D.

Mongolism: Ciba Foundation Monograph No. 25. Edited by C. E. Wolstenholme and Ruth Porter. Boston, 1967, Little-Brown. Pp. 99. (Price not stated).

The body of the booklet contains seven original contributions on specific studies together with round table discussion by the panelists. This is not a primer or comprehensive review of the subject but is, rather, a collection of highly sophisticated special studies with particular emphasis on cytogenetics.

Included is a "study of Down's Syndrome in Japan" which indicates that in Japan, as in Caucasian studies, "there is an increase in the relative incidence of this abnormality with maternal age." No support is found for the hypothesis that Down's Syndrome is sometimes the indirect result of the operation of recessive genes. Several contributions deal with such things as "DNA synthesis in cells grown in tissue culture from patients with mongolism"; DNA replication; and abnormal granulocyte kinetics. The bulk of this material presupposes familiarity not only with current biochemical knowledge of DNA as well as familiarity with cytogenetic terms, but highly specific correlations between such variables as clinical abnormalities, replication patterns of chromosomes numbers 21-22, and abnormal granulocyte kinetics. Workers interested in the field get a bird's-eye view of what the leading investigators are doing and what needs to be done in research.

A rewarding plum is given during the discussion at the end of the book when Dr. Waardenburg of Holland explains how (in 1932) he anticipated the discovery of translocation and monosonomy or trisomy of chromosomes in this condition. Bernard R. Goldberg, M.D.

Rehabilitation Services In Hospitals And Related Facilities. Chicago, 1966, American Hospital Association. Pp. 66. (Price not stated)

This booklet is an excellent guide to "Planning, Organization, and Management" through restorative service. It is prepared in outline form and provides the guide lines of policy and functioning for the instituting or continuation of Rehabilitation Medicine as an integral part of overall medical care.

Its presentation of the total role and scope of Rehabilitation Medicine is demonstrated by an example of patients who survive the initial stages of myocardial infarction. The example states that 85 per cent of original infarctions survive; that more than 60 per cent of these patients return to their previous or similar employment. This gives the methods used in obtaining these excellent results.

The book also discusses the available existing community and public health resources, how to reach and use them, as well as suggestions to meet future needs.

Also included is discussion of two approaches of developing a rehabilitation program within a community or medical facility. These are outlined and defined as a "goal" or an "additive" approach.

There is emphasis on the development of extended care facilities under current and evolving programs. This topic has great value for everyone concerned with the care of the chronically ill, and geriatric patient. Also covered is a clear definition of policy and management, the role of the administration versus medical needs and the value of medical leadership. This material should be reviewed many times by persons in both administrative and medical fields, and by all concerned with providing rehabilitation services.

Earl F. Hoerner, M.D.

Evolution and Human Behavior. Alexander Alland, Jr. New York, 1967, Natural History Press, Doubleday and Company. Pp. 243. Illustrated. (Hardcover: $5.95; Paperback: $1.45)

This could be a textbook "structured," as Dr. Alland states in his preface, "as an introduction to evolutionary theory and genetics for anthropology students." Lest this seemingly specialized approach deter the potential physician-reader let him be guided more by the title of the book. The author no more narrows his field to genes and clines than todays anthropologist limits his investigation to bones and teeth.

Dr. Alland presently teaches anthropology at Columbia University. His talents as a teacher are evident as he skillfully reviews Darwinian evolutionary theory and Mendelian genetics before discussing human behavior, culture, and social systems. His illustrations and examples are particularly apt and his pace such that interest never wanes.

The information put forth is necessary groundwork for an intelligent appreciation of some of the current problems of society. But Dr. Alland does not moralize, preferring a more scientific reticence at least in this book. In discussing the aim of research into biocultural evolution he believes a value orientation is not demanded. "We are interested in how human social systems work and how they develop, but we are not interested in such value-loaded concepts as progress or happiness."

James G. Foley, M.D.



Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

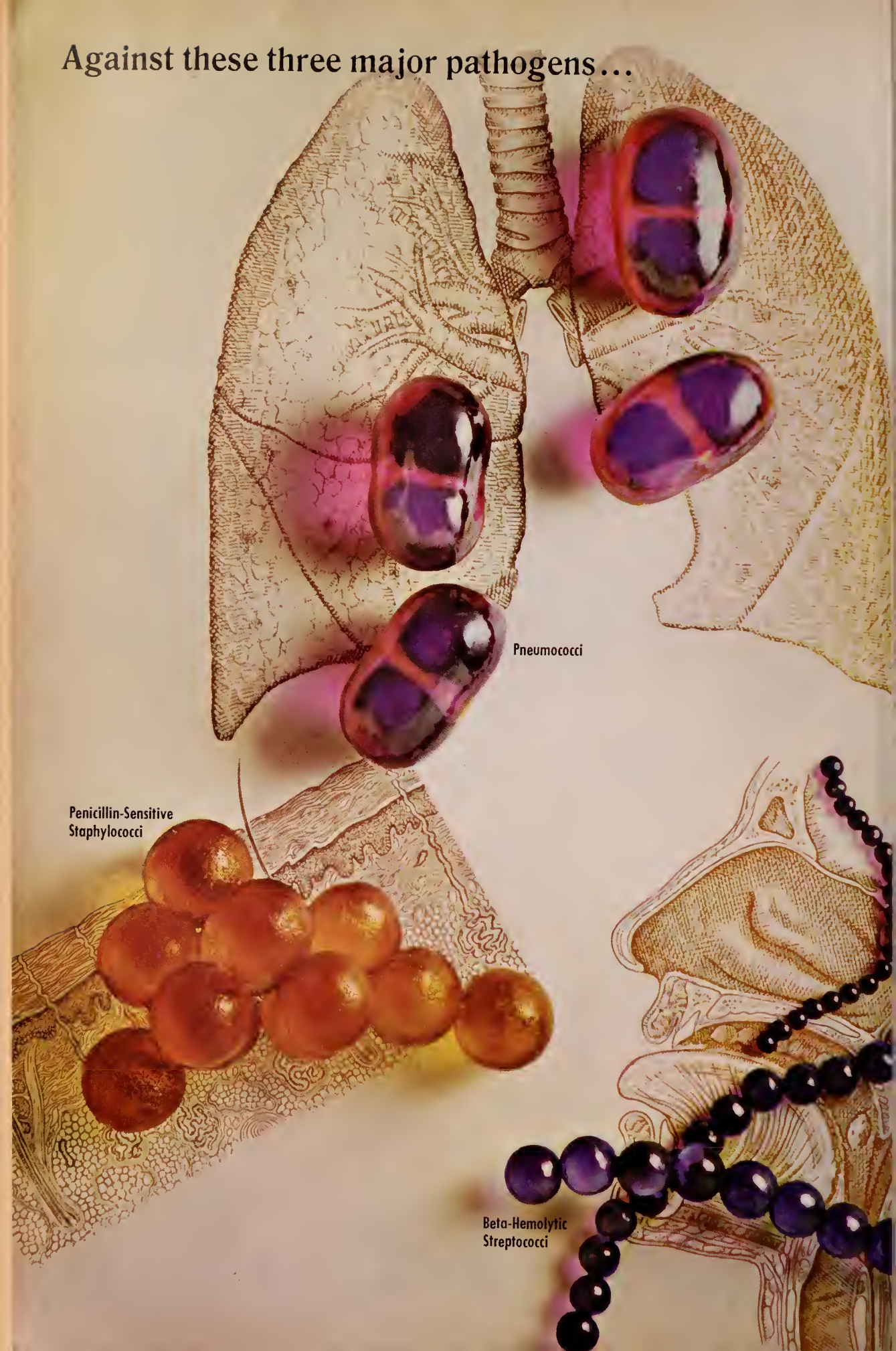
One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

Against these three major pathogens...



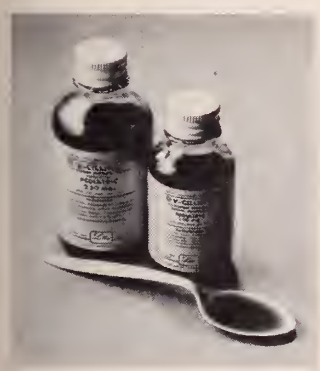
V-Cillin K® provides dependable oral antibacterial therapy

because it combines a high degree of activity...

V-Cillin K has been shown to be effective in the treatment of streptococcus and pneumococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy in patients with a history of rheumatic fever or congenital heart disease.

with high blood levels, even when taken with food

V-Cillin K is stable in acid and immediately soluble. High serum levels, therefore, are reached rapidly. Because it is acid stable, V-Cillin K is well absorbed even when taken close to mealtime. These desirable properties help make V-Cillin K a dependable penicillin for oral use.



V-Cillin K®

Lilly 701297

Potassium Phenoxymethyl Penicillin

Now available: V-Cillin K®, Pediatric, for Oral Solution, 250 mg. (400,000 units) per 5 cc. of solution.

(See next page for prescribing information.)

New 500 mg. tablets...a more convenient way to give high dose



Description: V-Cillin K is the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly). This chemically improved form combines acid stability with immediate solubility and rapid absorption. Higher serum levels are obtained more rapidly with this penicillin than with equal oral doses of penicillin G. The higher serum levels and acid stability of V-Cillin K make it a more dependable penicillin for oral use.

V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

Indications: V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Warnings: In rare instances, the use of penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin and in those with bronchial asthma or other allergies. Resuscitative drugs should be readily available for emergency administration. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for relief of immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particular... parenteral dosage schedules, frequent evaluation of th... hematopoietic systems is recommended.

In suspected staphylococcus infections, proper labor... (including sensitivity tests) should be performed.

The use of penicillin may be associated with the ov... pencillin-insensitive organisms. In such cases, its administr... be discontinued, and appropriate measures should be ta...

Adverse Reactions: Although serious allergic reactions a... common with administration of oral penicillin than with i... forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it does poss... cant index of sensitization. The following hypersensitivi... associated with the use of penicillin have been reported... ranging from maculopapular eruptions to exfoliative der... caria; and reactions resembling serum sickness, including... edema, arthralgia, and prostration. Severe and often fatal... has occurred (see Warnings). Hemolytic anemia, leukop... bocytopenia, and nephropathy are rarely observed side... are usually associated with high parenteral dosage.

Administration and Dosage: For Tablets V-Cillin K and fo... Pediatric, the usual dosage ranges from 125 mg. (200,000... times a day to 500 mg. (800,000 units) every four hours. ... the daily dosage may be 50 mg. per Kg. of body weight ... three doses.

Beta-hemolytic streptococcus infections without assoc... teremia may be treated with 200,000 to 400,0000 units th... day. Therapy should be continued for a minimum of ten days... development of rheumatic fever and/or other serious co... Dosage for routine streptococcus prophylaxis in patients wi... of rheumatic fever or congenital heart disease may be 20... once or twice daily. When such patients undergo tonsillec... extraction, or other minor surgery, the prophylactic dose... 500,000 units every six hours given two days prior to surg... two days postoperatively. If oral medication is not feasible... of surgery, parenteral therapy should be considered. Mild... ately severe pneumococcus pneumonia has been treated... with 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more shoul... every six to eight hours in conjunction with indicated surg... dures.

For gonorrhea in males, 500 mg. (800,000 units) every fou... three doses may be employed; in females, 500 mg. every... for six doses are recommended. Refractory infections general... to a second treatment three to four days following comple... first. Treatment of gonorrhea with severe complications... individualized, with prolonged and intensive treatment. Patie... suspected lesion of syphilis should have a dark-field exami... fore receiving penicillin and monthly serologic tests for a m... three months.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000... bottles of 50 and 100; and 250 mg. (400,0000 units) and... (800,000 units), in bottles of 24 and 100.

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000... 5 cc. of solution, in 40, 80, and 150-cc.-size packages.

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.



Diagnosis:

cystitis?
pyelonephritis?
pyelitis?
urethritis?
prostatitis?

in any case,
usually gram-negative*

Therapy:

two 500 mg. Caplets® q.i.d
(initial adult dose)

NegGram

Brand of

nalidixic acid

a specific anti-gram-negative

eradicates most urinary tract infections...

- Low incidence of untoward effects; no fungal overgrowth, crystalluria, ototoxic or nephrotoxic effects have been observed.
- "Excellent" or "good" response reported *in more than 2 out of 3* patients with either chronic or acute gram-negative infections.[1]

*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: E. coli, Klebsiella, Aerobacter, Proteus, Paracolon or Pseudomonas[2]... However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.

cations: Urinary tract infections caused by gram-negative and some gram-tive organisms.

effects: Mainly mild, transient gastrointestinal disturbances; in asional instances, drowsiness, fatigue, pruritus, rash, urticaria, mild nophilia, reversible subjective visual disturbances (overbrightness of ts, change in visual color perception, difficulty in focusing, decrease in al acuity and double vision), and reversible photosensitivity reactions. ked overdosage, coupled with certain predisposing factors, has produced convulsions in a few patients.

cautions: As with all new drugs, blood and liver function tests are advis- during prolonged treatment. **Pending further experience, like most notherapeutic agents, this drug should not be given in the first trimester regnancy. It must be used cautiously in patients with liver disease or ere impairment of kidney function.** Because photosensitivity reactions have urred in a small number of cases, patients should be cautioned to avoid ecessary exposure to direct sunlight while receiving NegGram, and if a tion occurs, therapy should be discontinued. The dosage recommended adults and children should not arbitrarily be doubled unless under the ful supervision of a physician. Bacterial resistance may develop.

n testing the urine for glucose in patients receiving NegGram, Clinistix® gent Strips or Tes-Tape® should be used since other reagents give a e-positive reaction.

age: Adults: Four Gm. daily by mouth (2 Caplets® of 500 mg. four times y) for one to two weeks. Thereafter, if prolonged treatment is indicated, dosage may be reduced to two Gm. daily. Children may be given roximately *25 mg. per pound* of body weight per day, administered in ded doses. The dosage recommended above for adults and children uld not arbitrarily be doubled unless under the careful supervision of a sician. Until further experience is gained, infants under 1 month uld not be treated with the drug.

v supplied: Buff-colored, scored Caplets® of **500 mg. for adults,** conve- ntly available in bottles of 56 (sufficient for one full week of therapy) and in les of 1000. **250 mg. for children,** available in bottles of 56 and 1000.

erences: (1) Based on 23 clinical papers, 1512 cases. Bibliography on uest. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: imicrobial Agents and Chemotherapy—1964, Ann Arbor, American iety for Microbiology, 1965, p. 722.

Winthrop

nthrop Laboratories, New York, N. Y. 10016

Sustained circulatory, respirator and cerebral stimulation for th

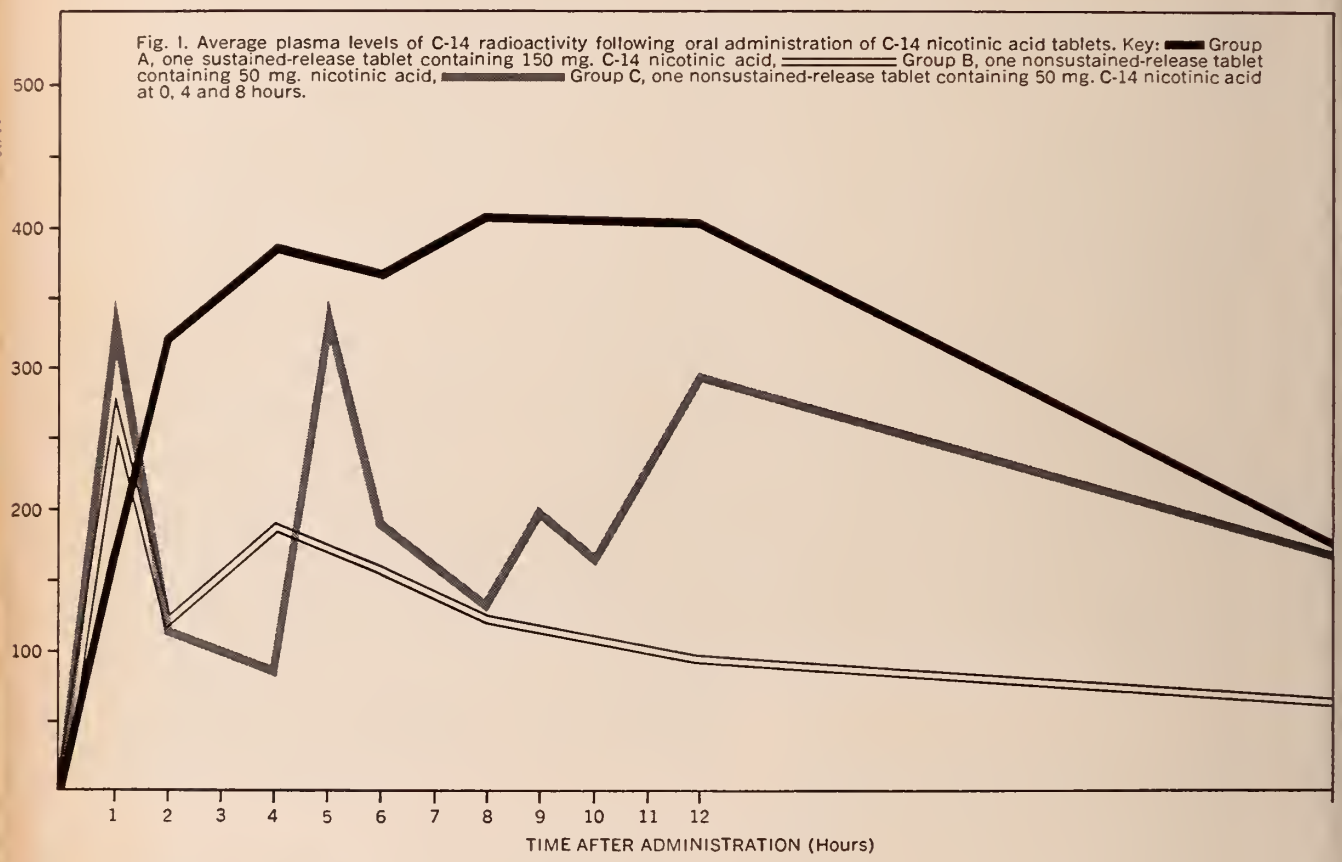


Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.



(fewer absent doses by absent-minded patients)

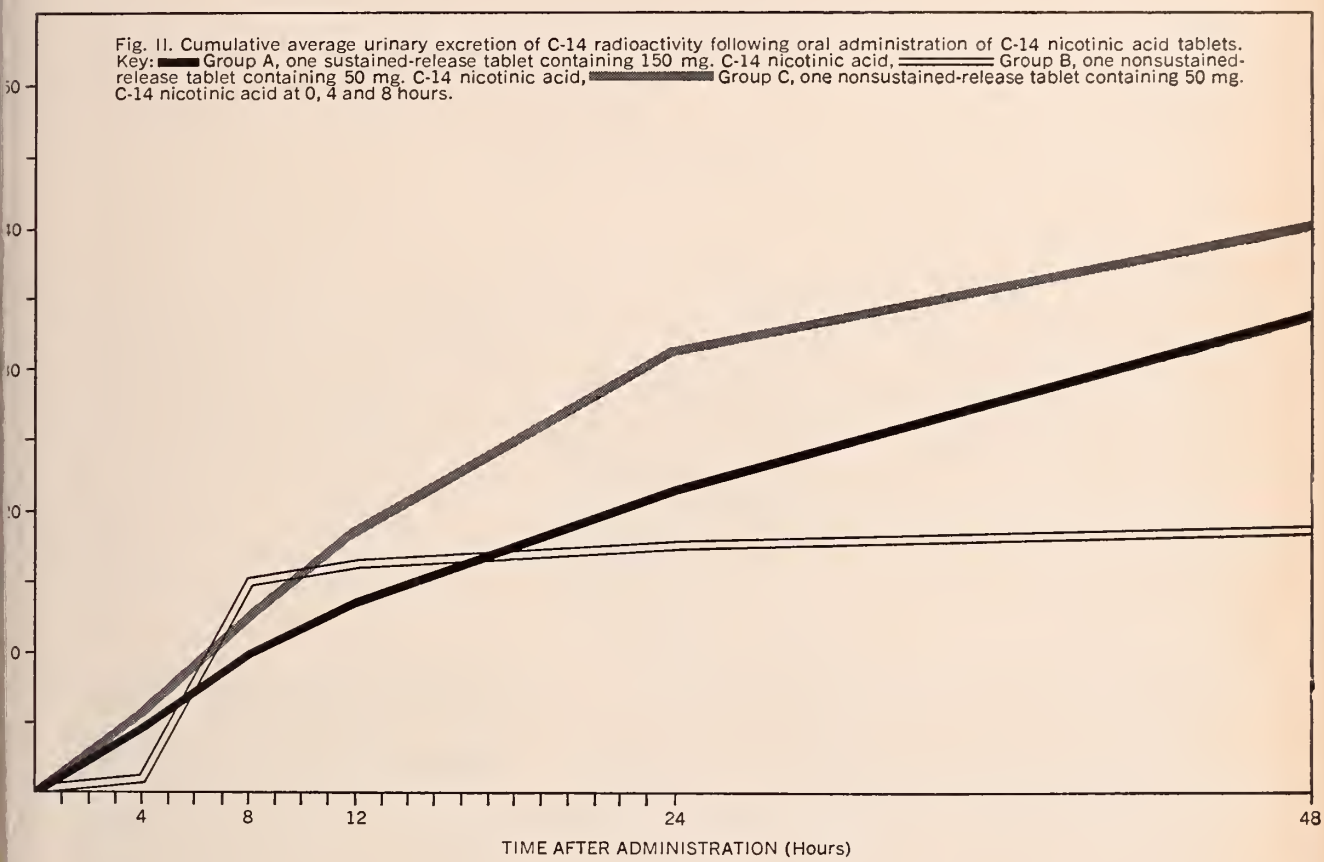
Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilatation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylenetetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

ed and debilitated



confused and moody. Personal care, memory, tional stability, social attention improve. Fatigue, thy and irritability are reduced.

prescription for 100 tablets of Geroniazol TT will nit your patients to enjoy the benefits of time-onged nicotinic acid/pentylenetetrazol therapy, n economical price. Dosage is only one tablet every ours.

traindications: There are no known contraindica-s.

autions: Exercise caution when treating patients a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

"First with the Retro-Steroids"
PHILIPS ROXANE LABORATORIES
Division of Philips Roxane, Inc., Columbus, Ohio
A Subsidiary of Philips Electronics and Pharmaceutical Industries Corp.

Geroniazol® TT

nicotinic acid 150 mg., pentylenetetrazol 300 mg.
Tempotrol® Time Controlled Tablet

"Prescribe With Confidence"

KATES BROS.

SCIENTIFIC SHOE FITTING

A Shoe and Last for Every Foot

Barefoot Freedom

SOLD ON Rx ONLY
CORRECTIVE FOOTWEAR FOR MEN - WOMEN - CHILDREN
OUTFLAIR SHOES FOR CLUB FEET

69 WESTWOOD AVENUE
WESTWOOD, N. J.

350 MAIN STREET
HACKENSACK, N. J.

Dennis Brown Splints — In all sizes — Carried in stock
CUSTOM SHOE SHOP ON PREMISES



DOCTOR,

Here is the expanded Abbott anorectic program designed to meet the individual needs of your overweight patients.



THE PRODUCT

ABBC
ANORECT
PROGRA

DESOXYN® Gradumet®

METHAMPHETAMINE HYDROCHLORIDE IN LONG-RELEASE DOSE FORM

5 mg. 10 mg. 15 mg.

DESBUTAL® 10 Gradumet

10 mg. METHAMPHETAMINE HYDROCHLORIDE, 60 mg. SODIUM PENTOBARBITAL

FRONT SIDE

DESBUTAL 15 Gradumet

15 mg. METHAMPHETAMINE HYDROCHLORIDE, 90 mg. SODIUM PENTOBARBITAL

FRONT SIDE

MOOD ELEVATION

DESOXYN Gradumet

Smooth appetite control plus mood elevation

Typically, the obese patient is a repeat dieter. And with each failure, the task looks more hopeless. Therefore, it is often just as important to lift the mood as to curb the appetite. Desoxyn Gradumet does just that. It gently elevates and sustains the mood. And no other product—amphetamine or non-amphetamine—is more effective in suppressing appetite.

DESBUTAL Gradumet

For patients who can't take plain amphetamine

Desbutal Gradumet contains 2 drugs, each in it own tablet section, combined back to back to forr a single tablet. One section contains Desoxyn t suppress the appetite and lift the mood; the othe contains Nembutal® (pentobarbital) to soothe th patient and counteract any excessive stimulatior The drugs are released in an effective dosage rati throughout the day.

CONTROLLED-RELEASE

HOW IT DIFFERS FROM LONG-RELEASE

The Gradumet is made up of thousands of interconnecting channels, much like a sponge. These channels—filled with a drug—end at the outer surface of the tablet. When fluid comes in contact with the Gradumet, the drug in the outer ends of the channels dissolves. As the fluid makes its way up the channels, there is a continuous release of medication.

Since the rate of release is rigidly determined by the size and number of channels, the Gradumet is able to provide controlled-release as well as long-release. Patients get a measured amount of medication, moment by moment, throughout the day—from a single oral dose.



THIS IS A RELEASE YOU CAN COUNT ON

THE PROGRAM

WEIGHT CONTROL BOOKLET

To help your obese patients understand why they are overweight—and what they can do about it—Abbott has a booklet called "The Secret of Controlling Your Weight." *It is available to your patients only through you.*

Here is a partial list of the topics covered:

- Why you are overweight
- Rewards of weight reducing
- Balanced meals
- Helpful hints
- Hunger between meals
- Snacks
- Weekly weighings
- Exercise
- Holidays, vacations, special events
- Leanness and longevity

Each topic is covered on one page in simple and easy-to-understand language. At the back of the booklet, there is a list of 160 foods showing their caloric content.



FOOD DIARY

The Food Diary is designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing everything down that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.

This booklet also lists the caloric content of 160 foods.



See Brief Summary on next page.

THE PRICE

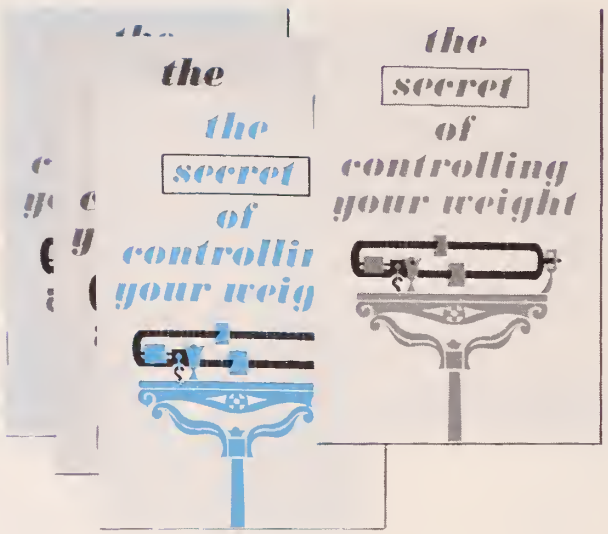
ECONOMY

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

Desoxyn Gradumet and Desbu Gradumet are so reasonably pric that patients in many cases sa enough (compared to other leadi long-release anoretics) to get fi weeks of medication for the pri of four.

FREE SUPPLIES





There are four weight control booklets, each with the same text, but with a different sample in the back of the booklet to meet your individual patient's needs. You have your choice of Desoxyn Gradumet in 10 mg. or 15 mg. strengths as well as Desbutal 10 Gradumet and Desbutal 15 Gradumet. The Food Diary is the same for all of the weight control booklets.

Your Abbott man will be happy to supply you with booklets. Just ask him.

CONTRAINDICATIONS: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates.

PRECAUTIONS, SIDE EFFECTS: Observe cau tion in patients with hypertension, cardiovascula disease, hyperthyroidism, old age, or those sensitiv to sympathomimetic drugs. Prolonged usage ma lead to tolerance or psychic dependence. Carefu supervision is necessary to avoid chronic intoxica tion and addiction.

Amphetamine side effects such as a headache, ex citement, agitation, palpitation or cardiac arrhythmi usually may be controlled by reducing the dose Paradoxically-induced depression is an indicatio to withdraw the drug. Pentobarbital (in Desbutal may cause skin rash. Nervousness or excessive sedation with Desbutal is usually transient.

701069

ABBOTT

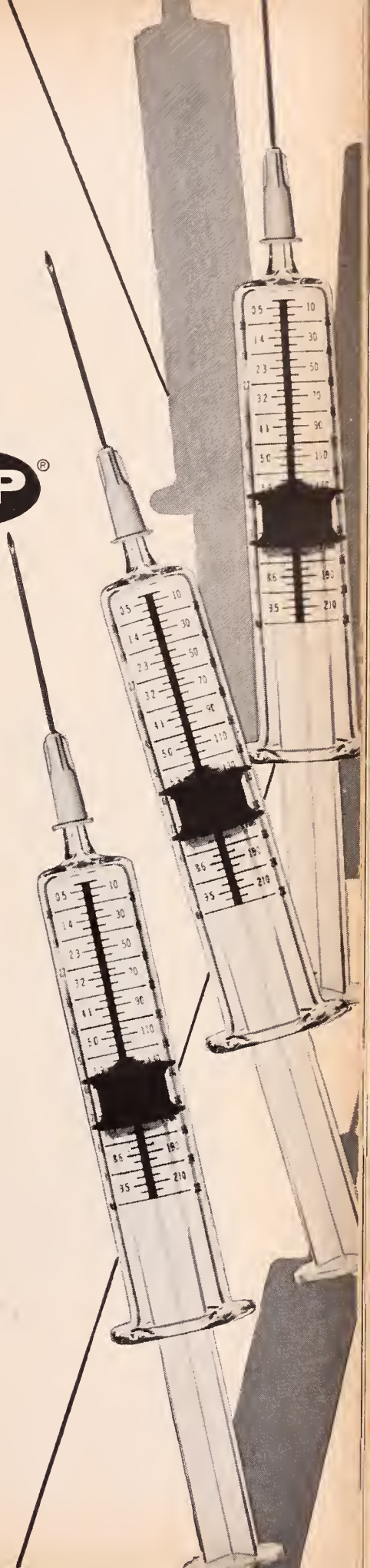
Gradumet—Long-release dose form, Abbott: U.S. Pat. No. 2,987,445.

BSP® DISPOSABLE UNIT

HW&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

(50 mg. per ml.)

BSP®



ROMSULPHALEIN®

IN A COMPLETE,

STERILE,

DISPOSABLE,

& ECONOMICAL

PATIENT-UNIT.

BSP, one of the more valuable single laboratory procedures for determining hepatic function, is now packaged in a complete individual patient-unit.

Each BSP Disposable Unit contains a sterile syringe with the 5 mg./kg. BSP dosage schedule imprinted on the barrel, a sterile needle, alcohol swab and a 7.5 ml. or 10 ml. size ampule of terminally sterilized Bromsulphalein solution.

This all-inclusive disposable put-up lessens the chance of cross-infection and saves time and labor— the most costly commodities.

HYNSON, WESTCOTT & DUNNING, INC.

HWD (BSP03)

BALTIMORE, MARYLAND 21201

IMPORTANT FACTS

about

Professional Liability Coverage

Insurance that only covers claims based on the rendering of, or failure to render, professional services, or arising out of malpractice error or mistake in rendering professional services, is no longer adequate.

Our policy, approved and recommended by The Medical Society of New Jersey is broad enough to cover:

(1) the non-negligent as well as the negligent claim, such as arising out of duties as committee member in your society or hospital.

(2) The financial loss to a physician in attending trial as a defendant in protracted litigation.

(3) punitive damages for libel or slander.

This program, which was designed with The Medical Society of New Jersey and its legal counsel, and operated by a cooperative Loss Control Program, offers this broad protection, security and continuity of coverage.

Complete protection should not
be controlled by price.

AMERICAN MUTUAL LIABILITY INSURANCE COMPANY

Policies Guaranteed Non-assessable

Professional Liability Department

725 PARK AVENUE EAST ORANGE, NEW JERSEY 07017
Joseph A. Britton, Manager ORange 3-2575
Home Office: Wakefield, Mass.

There are 69,700* undetected diabetics in New Jersey

Most of these are probably among patients over 40; the overweight; relatives of diabetics, and mothers of large babies. By the time polyphagia, polyuria, polydipsia, pruritus or other overt symptoms of diabetes appear, damage may have been done that could have been minimized. DEXTROSTIX® gives you a reliable blood-glucose estimate in 60 seconds.

Why Wait?



*Based on Statistical Report, U.S. Dept. Commerce, ed. 86, and Fisher, G. F., and Vavra, H. M.: Pub. Health Rep. 80:961 (Nov.) 1965.

Note: DEXTROSTIX is not meant to replace the more precise analytical laboratory procedures such as needed in glucose tolerance testing.

AMES COMPANY, Division Miles Laboratories, Inc., Elkhart, Indiana 46514 428R67

Ames

Not Just "Milk" But . . .

WALKER-GORDON CERTIFIED MILKS

There are many reasons why thousands of discriminating families have been raised from infancy on Walker-Gordon Certified Milks. Among the reasons:

- *Super-Sanitary Production Methods.* From cow to bottle, milk is never exposed to air or human touch.
- *Cleanest.* Lowest bacteria count. Laboratory on the farm.
- *Freshest.* Bottled immediately after milking, usually delivered the following day. Keeps for weeks under normal refrigeration.
- *Uniform.* No variance in flavor or nutritional value, 365 days a year.

Guaranteed Free of Antibiotic Residue

Certified Milks available through Leading Milk Dealers: Raw, Pasteurized, Homogenized-Vitamin D, Skimmed, Fresh Lo-Sodium. Write for complete information.

WALKER-GORDON CERTIFIED MILK FARM

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n sinusitis, colds, U. R. I.

)imetapp® Extentabs®

metane® [brompheniramine maleate], 12 mg.;
nylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)

p to 10-12 hours clear reathing on one tablet

It's clear—Dimetapp lets your "stuffed-up" patients breathe easy again. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. Its key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done...in a hurry.

ntraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy. **Precautions:** Until patient's ponse has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to ients with cardiac or peripheral vascular diseases or hypertension. **Side Effects:** Hypersensitivity reactions including skin rashes, icaria, hypotension and thrombocytopenia have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of mouth, mydriasis, increased irritability or excitement may be encountered. A. H. ROBINS COMPANY, Richmond, Virginia 23220

Supplied in Bottles of 100 and 500

A.H. ROBINS

Preludin® phenmetrazi hydrochlorid



For complete details,
please see full
Prescribing Information.

helps keep calories at arm's length

Preludin is indicated only as an anorectic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension, or pregnancy. For use in pregnancy, see Warning.

Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets® prolonged-action tablet a day, taken by midmorning.
Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.



Warning: Do not use during first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.
Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations, or delusions. Do not exceed recommended dosage.
Side Effects: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache. (B)R46-560-A

Geigy Pharmaceuticals, Division of Geigy Chemical Corporation, Ardsley, N.Y.

Under license from Boehringer Ingelheim G.m.b.H.

even in ulcerative colitis...

characterized by:
— diarrhea, cramps, tenesmus
— bloody, mucoid, purulent stools



LOMOTIL® tablets/liquid

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride 2.5 mg.
(Warning: May be habit forming)
atropine sulfate 0.025 mg.

controls diarrhea

In six published studies[1-6] detailed results are given on the use of Lomotil in 111 patients with chronic ulcerative colitis. They show that Lomotil gave satisfactory to "excellent" control of diarrhea in more than two-thirds of these patients. As the disorder advances and destroys bowel musculature, the motility-lowering action of Lomotil, understandably, has less effect.

The successful use of Lomotil in a disorder as exceedingly difficult to treat as moderate ulcerative colitis emphasizes again its unsurpassed antidiarrheal effectiveness in these more common conditions:

- **Gastroenteritis**
- **Acute infections**
- **Spastic colon**
- **Drug induced diarrhea**
- **Functional hypermotility**

For correct therapeutic effect
Rx correct therapeutic dosage

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are:

Children: Total Daily Dosage

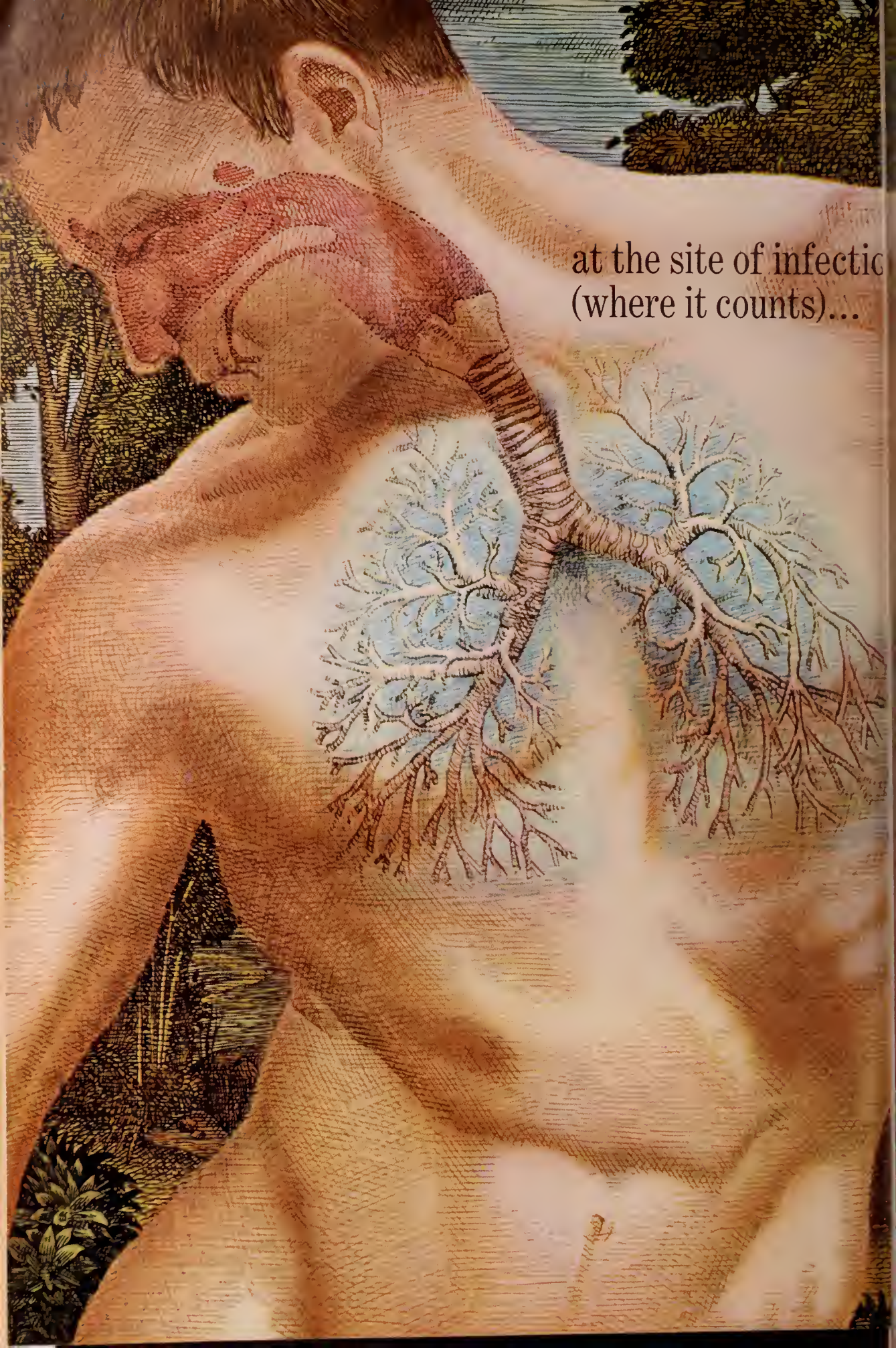
6-6 mo. . . ½ tsp.*t.i.d. (3 mg.)
6-12 mo. . ½ tsp. q.i.d. (4 mg.)
1-2 yr. . . . ½ tsp. 5 times daily (5 mg.)
2-5 yr. . . . 1 tsp. t.i.d. (6 mg.)
5-8 yr. . . . 1 tsp. q.i.d. (8 mg.)
8-12 yr. . . 1 tsp. 5 times daily (10 mg.)
Adults: 2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.

*Based on 4 cc. per teaspoonful.
Maintenance dosage may be as low as one-fourth the initial daily dosage.

Precautions: Lomotil is a federally exempt narcotic preparation of very low addictive potential. However, dosage should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and tachycardia. Lomotil should be used with caution in patients with impaired liver function or those taking addicting drugs or barbiturates.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of the extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

1. Barowsky, H., and Schwartz, S. A.: J.A.M.A. *180*:1058-1061 (June 23) 1962. 2. Cayer, D., and Sohmer, M. F.: N. Carolina Med. J. 22:600-604 (Dec.) 1961. 3. Hock, C. W.: J. Med. Ass. Georgia 50:485-488 (Oct.) 1961. 4. Van Derstappen, G., and Vandenbroucke, G.: Med. Klin. 56:962-964 (June 2) 1961. 5. Merlo, M., and Brown, C. H.: Amer. J. Gastroent. 34:625-630 (Dec.) 1960. 6. Weingarten, B.; Weiss, J., and Simon, M.: Amer. J. Gastroent. 35:628-633 (June) 1961.


at the site of infectio
(where it counts)...

Ilosone® provides more antibacterial activity than any other oral erythromycin

Acid stable, better absorbed... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food[1-3]

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

Now available:
New! Ready-mixed Ilosone Liquid 125! (Contains erythromycin estolate equivalent to 125 mg. erythromycin base per 5-cc. teaspoonful.)

700970

Ilosone®
Erythromycin Estolate

Lilly

(See next page for prescribing information.)

Ilosone®/the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have also been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with preexisting liver disease or dysfunction.

Adverse Reactions: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have developed in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly, usually within forty-eight hours, if the drug is readministered to sensitive patients. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence

In those cases mentioned above in which jaundice a be definitely related to use of the drug, laboratory fin characterized by increased direct-reacting bilirubin alkaline phosphatase levels, negative or weakly positiv flocculation and thymol turbidity tests, elevated serum oxalacetic transaminase levels, peripheral eosinophilia mal cholecystograms.

Individual idiosyncrasy seems evident since jaundi been reported in other patients taking prolonged cour medication. Patients with chronic infection have been to 2 Gm. of the drug daily for periods of two to six m patients with rheumatic fever have taken prophylacti 0.5 Gm. daily for two years without difficulty. In one 144 patients who received the drug daily for two years dice was noted. It was of interest that members of si patients' families, who were not taking the drug, ha of jaundice during the study period.

Transaminase and serum alkaline phosphatase le determined in a group of fifty-four adults and children 250 mg. of Ilosone daily for an average of sixteen r rheumatic fever prophylaxis. The results were comp those of a similar group of forty-four patients who rec icillin. There were no cases of jaundice in either group. of SGPT and serum alkaline phosphatase levels during t of treatment was observed in one patient treated wit and in two patients treated with penicillin. Seven othe in the group receiving Ilosone and four others in the group showed elevations in one of the tests at some tin administration of the drugs.

Very satisfactory therapeutic results, without toxic reported in 102 pediatric patients who received short-te day) courses of Ilosone in the treatment of streptococ tions. Results of liver function tests in these patie comparable to those in a similar control group who had penicillin.

Gastro-intestinal disturbances not associated with h fects are observed in a small proportion of individuals a of a local stimulating effect of the medication on the al tract; however, the normal intestinal gram-negative flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon wit of erythromycin, there have been occasional reports of u skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered ora

Ilosone Pulvules®, Ilosone Liquid 125, Ilosone, 125, Suspension, Ilosone Drops, Ilosone Chewable Tablets.

For infants and for children under twenty-five pound weight, the usual dosage is 5 mg. per pound every six h children twenty-five to fifty pounds, 125 mg. every s (Tablets Ilosone Chewable should be chewed or crus swallowed with water.)

For adults and for children over fifty pounds, the usua of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral eryth therapy should be considered.

In the treatment of syphilis, the recommended total d 20 to 30 Gm. given in divided doses for a period of ten t days. Close follow-up of the patient is necessary since mycin drugs have not had adequate evaluation in all s syphilis. Examinations of spinal fluid are recommended of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four d recommended. In the treatment of gonorrhea, patients suspected lesion of syphilis should have a dark-field exan before receiving antibiotics, and monthly serologic test be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and (equivalent to base), in bottles of 24 and 100.

Ilosone Liquid 125, Oral Suspension, U.S.P., 125 mg. (eq to base) per 5-cc. teaspoonful, in 60-cc. and pint-size pa

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (eq to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size pa

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 10- packages, with dropper calibrated at 25 and 50 mg.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent t in bottles of 50.

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:
2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:3
3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 1960.

DORSEY "FLU-GRAM"

DON'T BE LULLED BY RELATIVE LACK OF FLU LAST WINTER. THIS WINTER BE PREPARED: WHEN THE COMPLAINTS ARE COUGH AND CONGESTION, YOU CAN RELIEVE THESE SYMPTOMS WITH TUSSAGESIC TABLETS. ONE TIMED-RELEASE TABLET AT MORNING, MIDAFTERNOON AND BEDTIME BRINGS UP TO 24 HOURS' RELIEF FROM TROUBLESOME COUGH AND STUFFED AND RUNNY NOSE. TUSSAGESIC IS THE FAMOUS TRIAMINIC FORMULA, PLUS THREE OTHER PROVED CONSTITUENTS. MAKES PATIENTS MORE COMFORTABLE. FAST. ASK YOUR DORSEY REPRESENTATIVE FOR SUPPLY OF STARTER SAMPLES, OR IF FLU IS ALREADY EPIDEMIC, PHONE COLLECT. SEE BELOW.

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timed-release tablet contains:

Triaminic® (phenylpropanolamine hydrochloride 25 mg., pheniramine maleate 12.5 mg., pyrilamine maleate 12.5 mg.)	50 mg.
Dextromethorphan hydrobromide	30 mg.
Terpin hydrate	180 mg.
Acetaminophen	325 mg.

Dosage: Adults—1 tablet, swallowed whole to preserve timed-release feature, in morning, midafternoon and at bedtime. Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

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A breakthrough in the control of pain

Talwin®

brand of

pentazocine

(as lactate)

**a potent injectable non-narcotic—
may be used in place of morphine
and other narcotic analgesics**



A breakthrou in the control of pain

Talwin®

brand of

pentazocine

(as lactate)

a potent injectable non-narcotic— may be used in place of morphine and other narcotic analgesics

Talwin 30 mg. relieves pain usually as quickly and effectively as morphine 10 mg.*

whatever the intensity of the pain

whatever the cause of the pain

whatever the site† of the pain

whatever the chronicity of the pain

whatever the age†† of the patient

without the liability of narcotics

without the development of tolerance on prolonged use

with less risk of severe respiratory depression than with morphine

with less constipation

with less urinary retention

Clinical experience of more than 150 investig with over 12,000 patients given varying dosag Talwin shows that this potent injectable analg is not a narcotic.

Talwin has less risk of severe respiratory dep sion, urinary retention, and constipation than or phine—a great boon for postsurgical patients

Talwin produces less nausea, vomiting and phoresis than meperidine.

Constipation and urinary retention are seldo problem with Talwin.

Very rarely do hallucinations or disorientation cur (0.1% each).

No significant hepatic, renal, hematopoietic or rologic disturbances have been reported.

Talwin is well tolerated even by the aged or ve patients.

Used during active labor, its tolerance by mother and newborn is comparable to mep dine's. As with all new drugs, Talwin should be u with caution in pregnant women and in women livering premature infants.

Tolerance to the analgesic effect of Talwin has developed with prolonged use.

Talwin gives significant relief of pain in from 1 20 minutes following I.M. or S.C. injection.

Talwin relieves pain usually for 3 hours or lon with a single injection; however, the duration sometimes be less than with morphine.

*Its duration of action may sometimes be less than that of morphine.

†Should not be used for patients with increased intracranial pressure, head injury or pathologic brain conditions.

††Until sufficient experience is gained, Talwin should not be administered to children under 12 years of age.

86 per cent of medical and surgical patients obtained excellent to good relief with Talwin 30 mg. administered parenterally

Talwin

rand of pentazocine (as lactate)

used for pain of all types

Talwin has a wide range of usefulness in surgery

ypes of surgical use	Number of patients	Efficacy				
		% Exc.	% Good	Exc. + Good	% Fair	% Poor
Preoperative	118	31	52	83%	15	2
Postoperative	914	58	28	86%	8	6
Pre- and postoperative	12	75	17	92%	0	8
Minor surgery	33	30	39	69%	0	31*
Traumatic	14	64	29	93%	7	0
Dental	33	67	24	91%	3	6
Total patients.....1124						

fficacy of 30 mg. Talwin I.M. and S.C. as related types of surgical use in a cooperative study

ta in files of Department of Medical Research, Winthrop Laboratories.

gh incidence of poor results in minor surgery is due primarily to one udy involving change of burn dressings in children; 9 of 19 patients ob- ned poor results with dose used.

alwin relieves all types f pain in acute and hronic medical disorders

pe of medical pain	Number of patients	Percentage of relief				
		Excellent	Good	Exc. + Good	Fair	Poor
Malignancy, pain in	161	44	37	81%	8	11
rthopedic; see also "Arthritis"	111	53	38	91%	5	4
ardiovascular pain; see also "Miscellaneous medical"	96	59	27	86%	6	7
enitourinary pain	83	42	33	75%	16	10
rthritis	76	33	51	84%	12	4
ynecologic pain	35	57	34	91%	6	3
ephalalgia	21	45	41	86%	9	5
astrointestinal pain	19	89	5	94%	0	5
hest, including • Pleurisy • Pulmonary embolism and infarct • Lung abscess	12	83	17	100%	0	0
iscellaneous medical, including • Peripheral vascular disease • Thrombophlebitis • Cervical root pain • Facial neuralgia • Syringomyelia • Burns	108	50	39	89%	9	2
Total patients.....722						

ficacy of 30 mg. Talwin I.M. and S.C. as related types of medical pain in a cooperative study

a in files of Department of Medical Research, Winthrop Laboratories.

e next page for additional product information

Talwin relieves pain as quickly as morphine

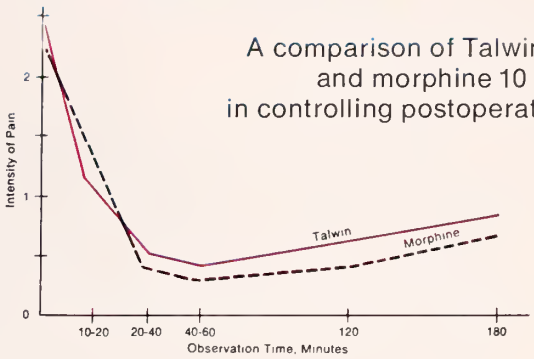


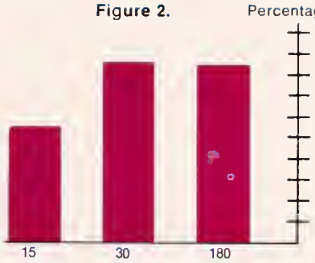
Figure 1.

Talwin 30 mg. proved equivalent to morphine 10 mg. in overall analgesic efficacy. During the early post-medication period (up to 40 minutes after drug injection), Talwin was superior in effect to morphine.

After observation periods ranging from 40 to 180 minutes there was no difference between the drugs in their effect on intensity. There were 141 and 119 complete patient records for Talwin and morphine, respectively, in this double-blind study. Other clinical investigators, studying duration, state that relief with Talwin may be obtained for up to three hours or longer, a period sometimes less than morphine's.

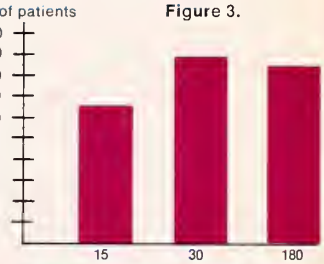
Talwin is as effective for severe pain (Fig. 2)† as for moderate pain (Fig. 3)†

Figure 2.



Per cent excellent to good relief of severe pain obtained with 30 mg. Talwin in 218 postoperative patients

Figure 3.



Per cent excellent to good relief of moderate pain obtained with 30 mg. Talwin in 203 postoperative patients

Talwin does not require a narcotics prescription or narcotics records

The World Health Organization Expert Committee on Dependence-Producing Drugs concluded that "...there was no need at this time for narcotics control of pentazocine [Talwin] internationally or nationally."‡

*Storer, E. H.: Data in the files of the Sterling-Winthrop Research Institute.

†Cooperative study, data in the files of the Department of Medical Research, Winthrop Laboratories.

‡*World Health Organization Technical Report Series*, No. 343, 1966, p. 6.

A breakthrough in the control of pain

Talwin®

brand of

pentazocine

(as lactate)

a potent injectable non-narcotic—may be used in place of morphine and other narcotic analgesics

Contraindications: *Increased Intracranial Pressure, Head Injury, or Pathologic Brain Conditions in which clouding of sensorium is undesirable.* Talwin (brand of pentazocine) should not be administered in these cases, since drug-induced sedation, dizziness, nausea, or respiratory depression could be misleading.

Precautions: *Pregnancy.* No teratogenic or embryotoxic effects attributable to the use of Talwin have been seen in extensive reproductive studies in animals; however, like all new drugs, Talwin should be given with caution to pregnant women. A large number of patients in labor have received the drug with no adverse reactions other than those that occur with commonly used strong analgesics. However, as with other strong analgesics, Talwin should be used with caution in women delivering premature infants.

Ambulatory Patients. Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

Certain Respiratory Conditions. The possibility that Talwin (brand of pentazocine) may cause respiratory depression should be considered in treatment of patients with bronchial asthma. Talwin should be administered only with caution and in low dosage to patients with respiratory depression (e.g., from other medication, uremia, or severe infection), obstructive respiratory conditions, or cyanosis.

Patients Dependent on Narcotics. Because Talwin is a narcotic-antagonist, patients dependent on narcotics and receiving Talwin may occasionally experience certain withdrawal symptoms. Talwin should be given with special caution to such patients. It has been observed that some patients previously given narcotic-analgesics for one month or longer had mild withdrawal symptoms when the drug was replaced with the analgesic, Talwin. After a short period of adjustment the subjects were usually able and willing to continue taking Talwin, and relief of pain was satisfactory.

Nonaddicted Patients Receiving Narcotics. Symptoms believed to be indicative of antagonism to the opiate may be observed rarely with administration of Talwin to patients receiving opiates for a short time. Intolerance or untoward reactions are seldom observed after administration of Talwin to patients who have received single doses or who have had limited exposure to narcotics.

Impaired Renal or Hepatic Function. Although laboratory tests have not indicated that Talwin (brand of pentazocine) causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment. Extensive liver disease appears to predispose to greater side effects (e.g., marked apprehension, anxiety, dizziness, sleepiness) from the usual clinical dose, and may be the result of decreased metabolism of the drug by the liver.

Myocardial Infarction. As with all drugs, Talwin (brand of pentazocine) should be used with caution in patients with myocardial infarction who have nausea or vomiting.

Biliary Surgery. Until further experience is gained with the effects of Talwin on the sphincter of Oddi, the drug should be used with caution in patients about to undergo surgery of the biliary tract.

Adverse Effects: Talwin is relatively free from the undesirable effects associated with morphine, such as constipation, urinary r tion, or severe respiratory depression. Furthermore, Talwin proc less nausea, vomiting, and diaphoresis than meperidine.

In over 12,000 patients who received Talwin intramuscularly, sub neously, or intravenously, nausea, the most frequent adverse e occurred in approximately 5.0 per cent. In decreasing order o currence were vertigo, dizziness or lightheadedness; vomiting; euphoria. Respiratory depression was reported as an adverse rea in 1.0 per cent.

The incidence of each of the other adverse effects was well b 1.0 per cent: constipation, circulatory depression, diaphoresis, ur retention, alteration in mood (nervousness, apprehension, depres floating feeling), hypertension, sting on injection, headache, mouth, flushed skin including plethora, altered uterine contract during labor, dermatitis including pruritus, dreams, paresthesia, dyspnea occurred rarely after administration of Talwin (brand of tazocine). Furthermore, each of the following adverse reactions curred in less than 0.1 per cent: tachycardia, visual disturb (blurred vision, diplopia and nystagmus), hallucinations, disorie tion, weakness or faintness, muscle tremor, chills, allergic react including edema of the face, taste alteration, insomnia, diarr cramps, and miosis; laryngospasm in one patient.

Talwin has not produced severe respiratory embarrassment in ac (never apnea), even with large amounts. A small number of newt infants whose mothers received Talwin during labor had trans apnea. The incidence of temporary diminution in the rate or stre of uterine contractions is low after administration of Talwin, sim to that following meperidine hydrochloride. (In reporting no inte ence with normal labor in patients receiving Talwin, one investig further stated that the drug may increase uterine activity.) Gener no significant fetal heart rate change occurs.

Laboratory tests of blood and of liver and kidney functions have vealed no significant abnormalities. A minimum and probably insig cant increase in the per cent of eosinophils in peripheral bl counts and bone marrow occurred occasionally.

Talwin is well tolerated by patients with diabetes mellitus, and changes in insulin requirements have been observed.

Dosage and Administration: *Adults, Excluding Patients in Labor.* A age recommended single parenteral dose is 30 mg., by intramuscu subcutaneous, or intravenous route; may be repeated every three four hours. Pain has been relieved in most patients with not m than three doses daily. Infrequently, selected patients have rece single doses as high as 60 mg.

Patients in Labor. A single, intramuscular 30 mg. dose has been m commonly administered. An intravenous 20 mg. dose has given a quate pain relief to some patients in labor when contractions beco regular, and this dose may be given two or three times at two- three-hour intervals, as needed.

Children Under 12 Years of Age. Since clinical experience in child under twelve years of age is limited, the use of Talwin (brand of p tazocine) in this age group is not recommended.

Duration of Therapy. Patients with chronic pain who received Talw for prolonged periods (e.g., over 300 days) experienced no wi drawal symptoms even when administration was stopped abrupt furthermore, there was no tolerance to the analgesic effect.

CAUTION. Talwin should not be mixed in the same syringe with s uble barbiturates because precipitation will occur.

Treatment of Overdosage or Respiratory Depression. Talwin has r produced apnea or severe respiratory embarrassment in adults, ev in large doses. Occasionally, however, moderate respiratory depre sion may occur. Means of maintaining proper oxygenation should available in case of overdosage or respiratory depression, and meth phenidate (Ritalin®) should be administered parenterally. The us narcotic-antagonists, such as nalorphine, are not effective respirat stimulants for depression due to Talwin.

How Supplied: Ampuls of 1 ml., containing Talwin® (pentazocine) lactate equivalent to 30 mg. base and 2.8 mg. sodium chloride, Water for Injection. **Boxes of 10, 25, and 100.**

Multiple dose vials of 10 ml., each 1 ml. containing Talwin® (pentaz cine) as lactate equivalent to 30 mg. base, 2 mg. acetone sodiu bisulfite, 1.5 mg. sodium chloride, and 1 mg. methylparaben as pr servative, in Water for Injection. **Boxes of 1.**

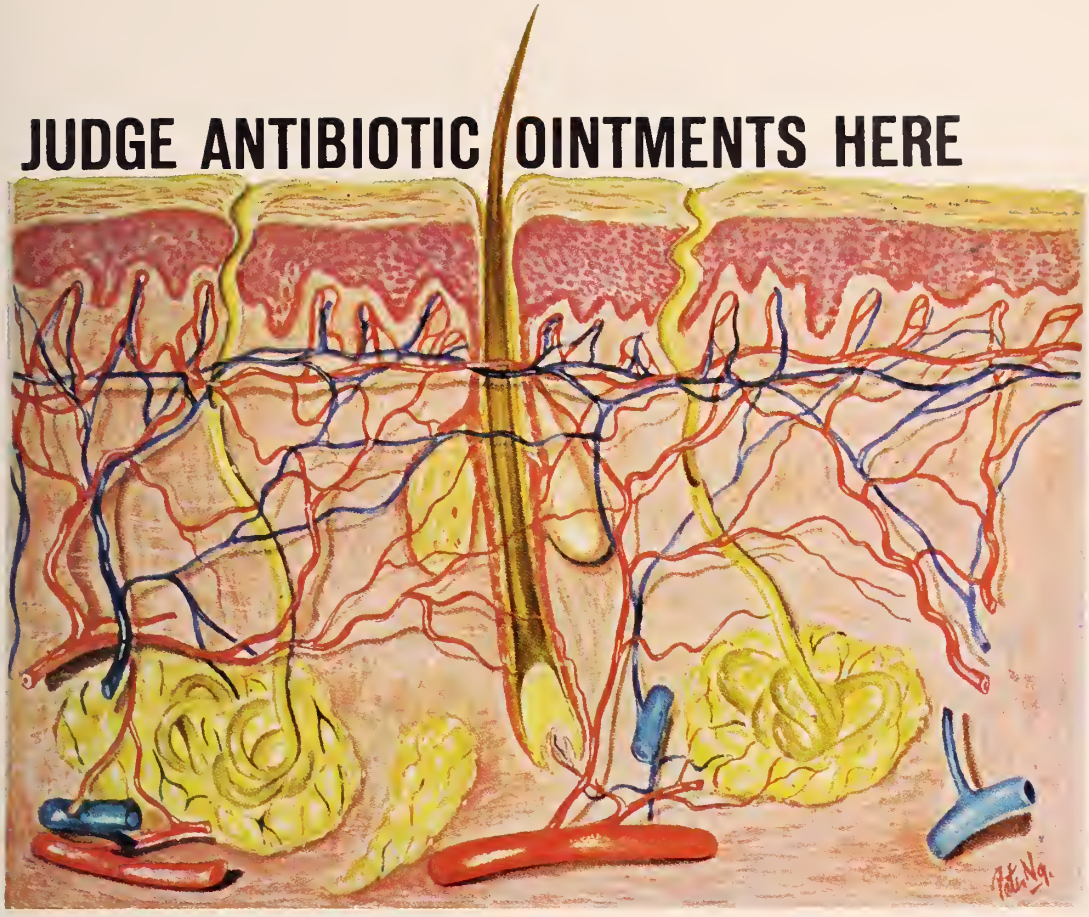
The pH of Talwin solutions is adjusted between 4 and 5 with lact acid and sodium hydroxide.

Winthrop

Winthrop Laboratories, New York, N.Y. 10016

PRINTED IN U.S.A. ISSUED AUGUST, 1967

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Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

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brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.



The full ¼ grain of phenobarb in the formula

takes the nervous edge off the pain ...helps bring out the best in codeine

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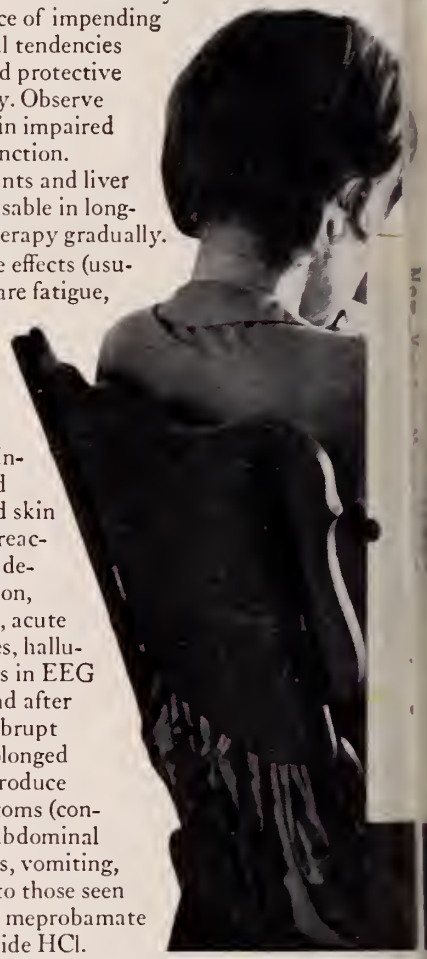


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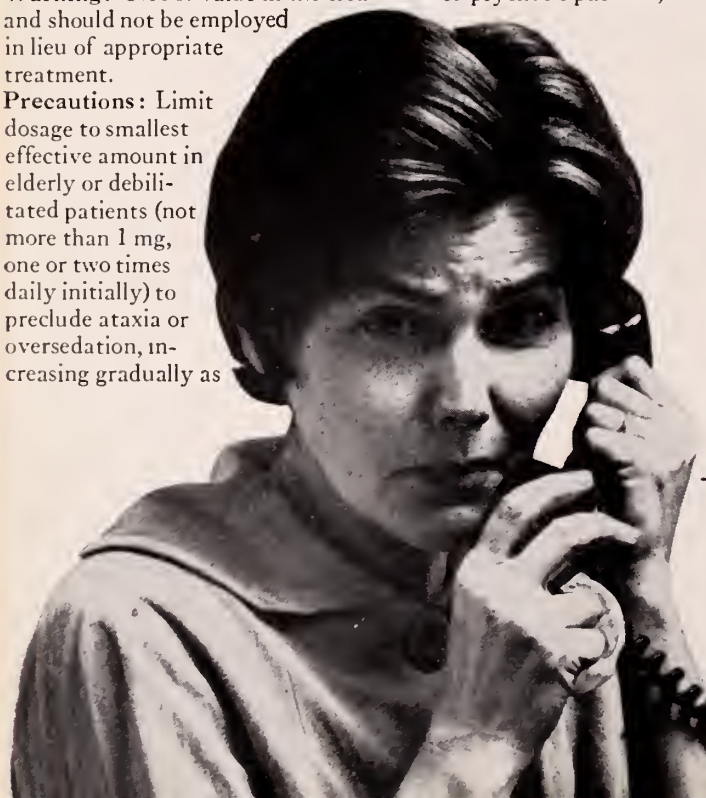


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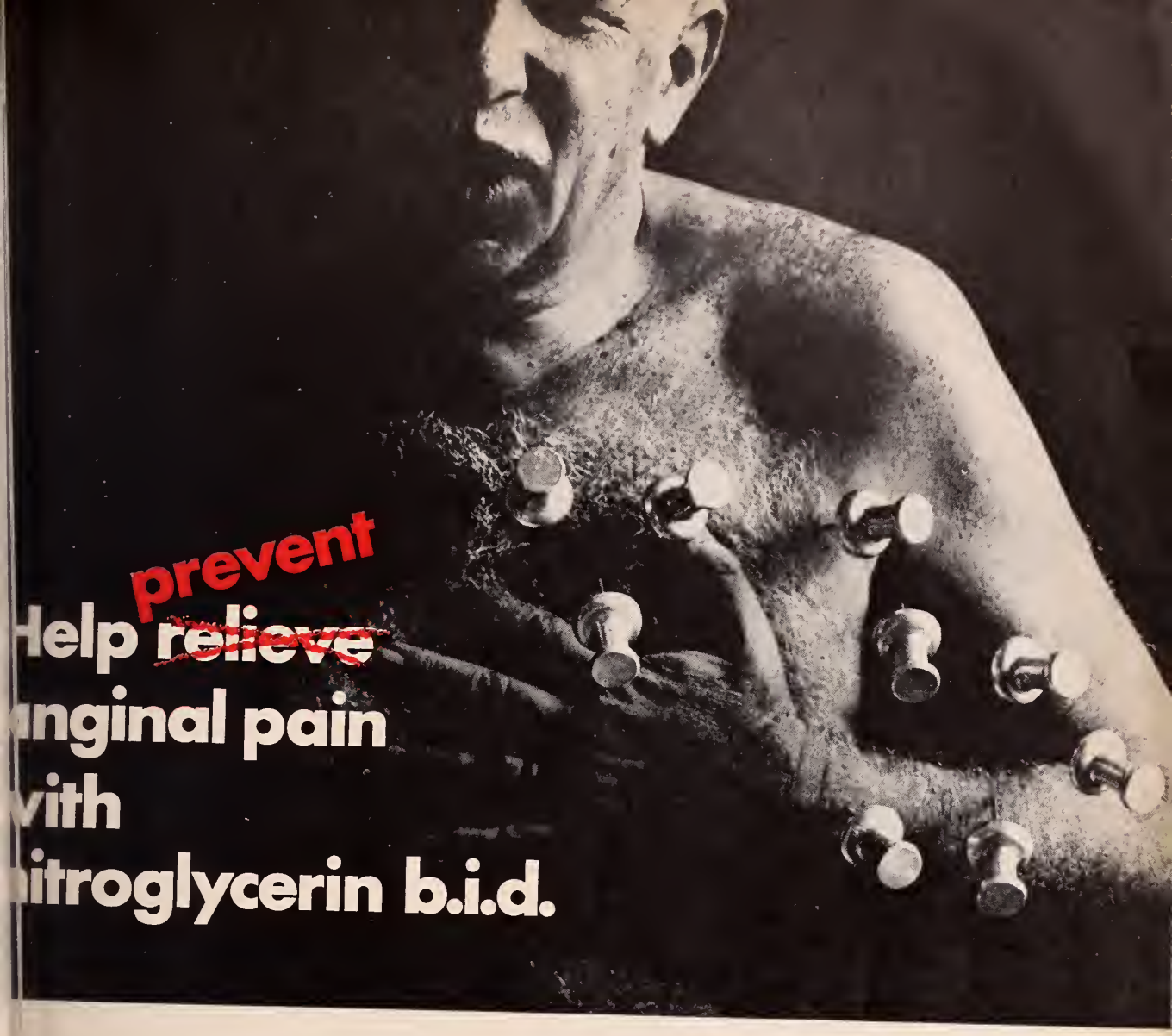
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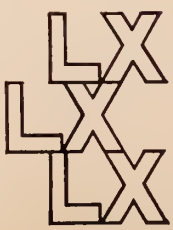
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Walker

QUINAMM™

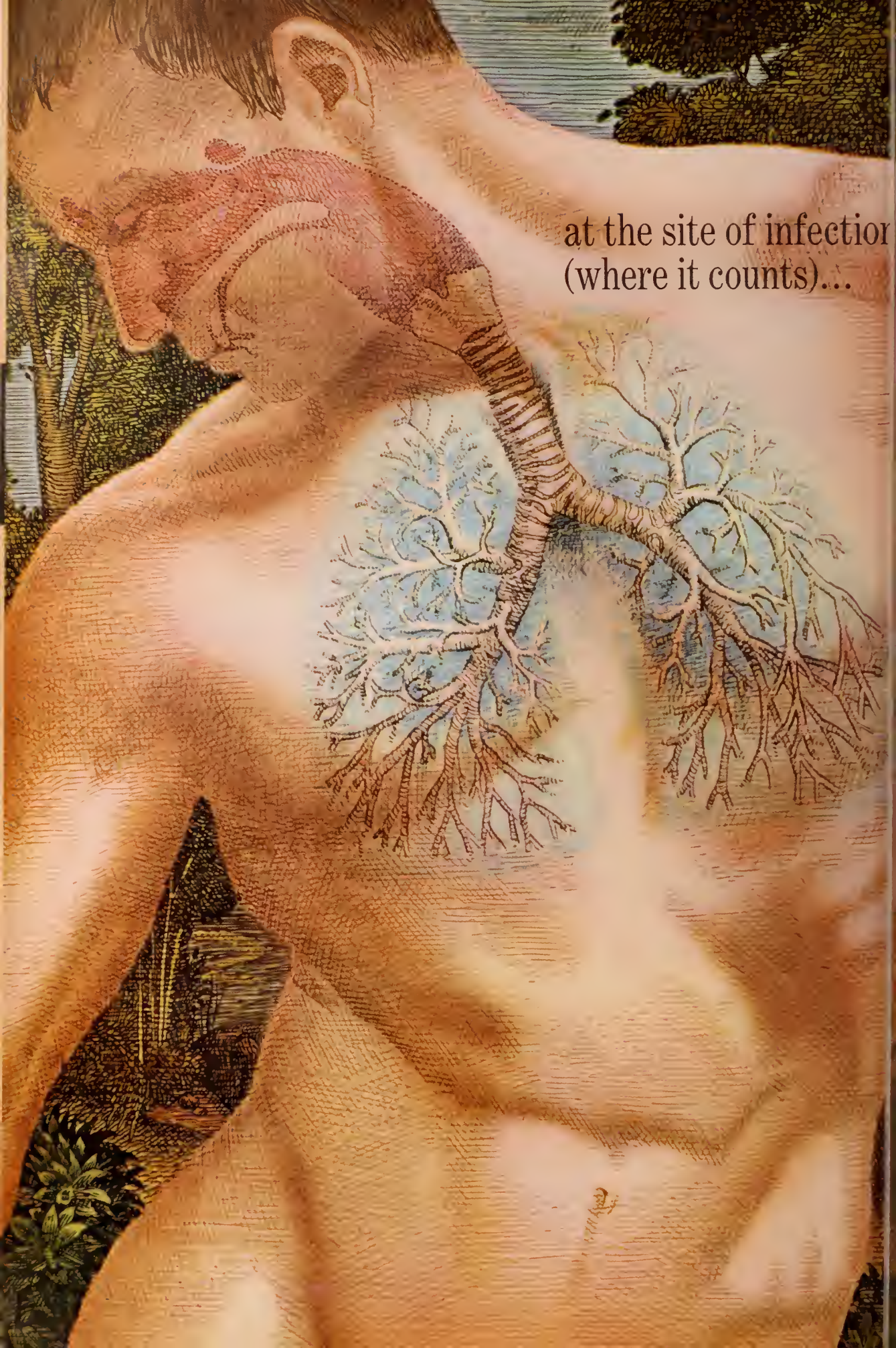
Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.[3] Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

Prescribing Information: Composition: Each white, beveled, compressed tablet contains: Quinine Sulfate 260 mg. and Aminophylline 195 mg. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

References: 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rowls, W., et al.: Med. Times, 87:818, 1959.

6/67 Q-706A


at the site of infection
(where it counts)...

Ilosone® provides more antibacterial activity than any other oral erythromycin

Acid stable, better absorbed... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food[1-3]

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.[1,2] Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.[1,3]

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

Now available:
New! Ready-mixed Ilosone Liquid 125! (Contains erythromycin estolate equivalent to 125 mg. erythromycin base per 5-cc. teaspoonful.)

701464

Ilosone®
Erythromycin Estolate

Lilly

(See next page for prescribing information.)

Ilosone®/the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by micro-organisms sensitive to its action—especially staphylococci, hemolytic streptococci, and pneumococci.

It has been effective in streptococcus infections, particularly acute bacterial pharyngitis and tonsillitis; staphylococcus disease, including soft-tissue infections, furunculosis, abscesses, cellulitis, carbuncles, and wound infections; pneumococcus pneumonia and acute bronchitis with pneumococci on culture, bronchopneumonia, and otitis media.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents; surgical procedures should be performed when indicated, and large doses of the antimicrobial agents should be employed.

Penicillin is the drug of choice for syphilis and gonorrhea, but Ilosone in multiple 500-mg. doses has been useful in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Known history of sensitivity to this drug; preexisting liver disease or dysfunction.

Adverse Reactions: Hepatic dysfunction with or without clinical jaundice has been reported infrequently. Changes in liver function tests indicative of intrahepatic cholestasis appear to be the result of individual idiosyncrasy. Findings subsided when treatment was discontinued. Occasionally, symptoms simulated extrahepatic obstructive jaundice or the colic of biliary tract disease.

When jaundice appeared to be related to use of the drug, laboratory findings were characterized by increased direct-reacting bilirubin, elevated alkaline phosphatase levels, negative or weakly positive cephalin flocculation and thymol turbidity tests, elevated serum glutamic oxalacetic transaminase levels, peripheral eosinophilia, and normal cholecystograms.

Gastro-intestinal disturbances not associated with hepatic effects and occasional allergic manifestations (urticaria, skin eruptions, and, rarely, anaphylaxis) have been reported. The normal intestinal gram-negative bacterial flora is not appreciably altered by erythromycin drugs.

Administration and Dosage: Ilosone is administered orally.

Infants and children under twenty-five pounds, 5 mg. per pound every six hours; twenty-five to fifty pounds, 125 mg. every six hours. Adults and children over fifty pounds, 250 mg. every six hours.

For severe infections, double the dosage. When larger doses are indicated, consider parenteral erythromycin therapy. In beta-hemolytic streptococcus infections, maintain treatment for ten days to prevent rheumatic fever or glomerulonephritis.

In syphilis, a total of 20 to 30 Gm. is administered in divided doses for ten to fifteen days. Close follow-up is necessary since erythromycin drugs have not had adequate evaluation in all stages of syphilis. Examination of spinal fluid is recommended during follow-up.

In gonorrhea, the dosage is 500 mg. four times a day for four days. Patients with a suspected lesion of syphilis should have a dark-field examination before receiving antibiotics and monthly serologic tests for three months. For detailed information, consult the package literature.

How Supplied: Pulvules® Ilosone, Capsules, N.F., 125 mg.* and 250 mg.*

Ilosone Liquid 125, Oral Suspension, U.S.P., 125 mg.* per 5-cc. teaspoonful.

Ilosone, 125, for Oral Suspension, N.F., 125 mg.* per 5-cc. teaspoonful.

Ilosone Drops, 5 mg.* per drop.

Tablets Ilosone Chewable, N.F., 125 mg.*

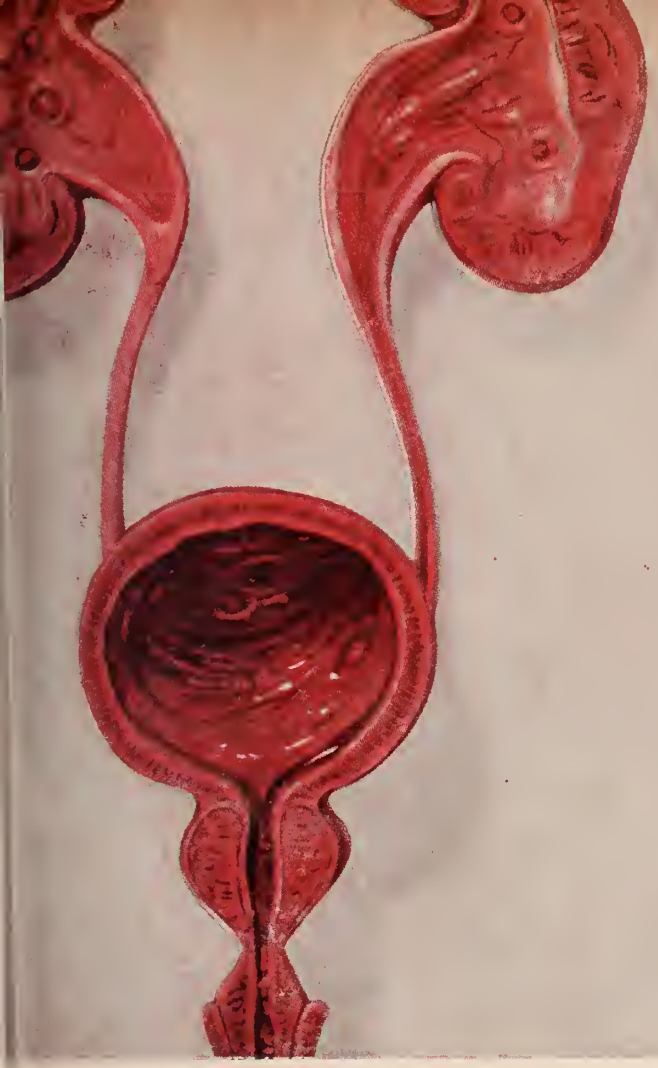
*Base equivalent. [080967]

References: 1. Griffith, R. S., and Black, H. R.: Am. J. M. Sc., *247*:69, 1964. 2. Griffith, R. S., and Black, H. R.: Antibiotics & Chemother., *12*:398, 1962. 3. Hirsch, H. A., Pryles, C. V., and Finland, M.: Am. J. M. Sc., *239*:198, 1960.

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

Lilly

701464



Diagnosis:

cystitis?
pyelonephritis?
pyelitis?
urethritis?
prostatitis?

in any case,
usually gram-negative*

Therapy:

two 500 mg. Caplets® q.i.d.
(initial adult dose)

NegGram

Brand of

nalidixic acid

a specific anti-gram-negative

eradicates most urinary tract infections...

- Low incidence of untoward effects; no fungal overgrowth, crystalluria, ototoxic or nephrotoxic effects have been observed.

- "Excellent" or "good" response reported *in more than 2 out of 3* patients with either chronic or acute gram-negative infections.[1]

*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: E. coli, Klebsiella, Aerobacter, Proteus, Paracolon or Pseudomonas[2]... However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.

ii lions: Urinary tract infections caused by gram-negative and some gram-s e organisms.

lfects: Mainly mild, transient gastrointestinal disturbances; in onal instances, drowsiness, fatigue, pruritus, rash, urticaria, mild phillia, reversible subjective visual disturbances (overbrightness of change in visual color perception, difficulty in focusing, decrease in acuity and double vision), and reversible photosensitivity reactions. l overdosage, coupled with certain predisposing factors, has produced onvulsions in a few patients.

tions: As with all new drugs, blood and liver function tests are advis-ring prolonged treatment. **Pending further experience, like most herapeutic agents, this drug should not be given in the first trimester nancy. It must be used cautiously in patients with liver disease or impairment of kidney function.** Because photosensitivity reactions have d in a small number of cases, patients should be cautioned to avoid ssary exposure to direct sunlight while receiving NegGram, and if a occurs, therapy should be discontinued. The dosage recommended ts and children should not arbitrarily be doubled unless under the supervision of a physician. Bacterial resistance may develop.

esting the urine for glucose in patients receiving NegGram, Clinistix® t Strips or Tes-Tape® should be used since other reagents give a sitive reaction.

: Adults: Four Gm. daily by mouth (2 Caplets® of 500 mg. four times r one to two weeks. Thereafter, if prolonged treatment is indicated, age may be reduced to two Gm. daily. Children may be given nately *25 mg. per pound* of body weight per day, administered in doses. The dosage recommended above for adults and children ot arbitrarily be doubled unless under the careful supervision of a n. Until further experience is gained, infants under 1 month ot be treated with the drug.

plied: Buff-colored, scored Caplets® of **500 mg. for adults,** conve-available in bottles of 56 (sufficient for one full week of therapy) and in f 1000. **250 mg. for children,** available in bottles of 56 and 1000.

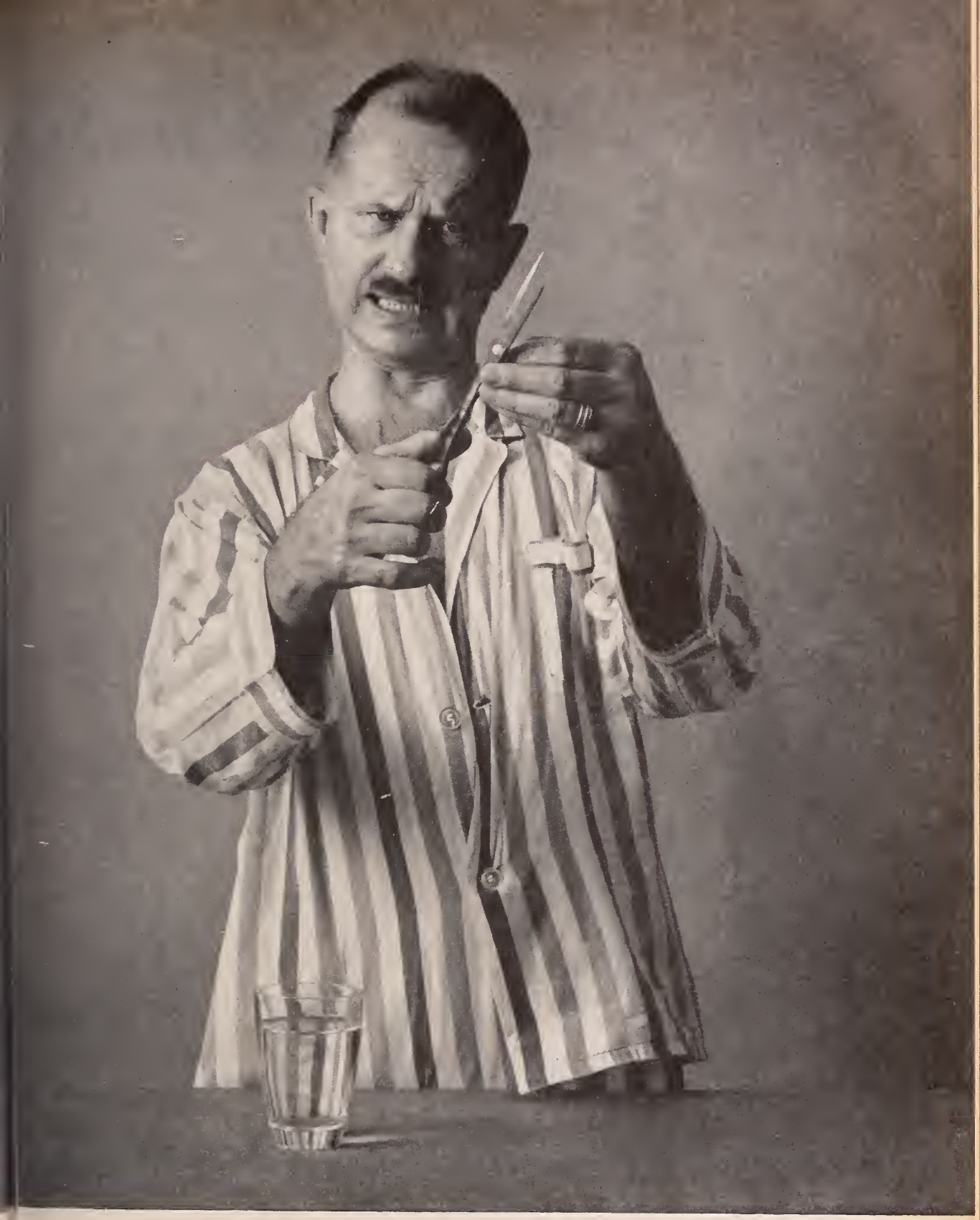
ces: (1) Based on 23 clinical papers, 1512 cases. Bibliography on (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: obial Agents and Chemotherapy—1964, Ann Arbor, American for Microbiology, 1965, p. 722.

Upjohn

op Laboratories, New York, N. Y. 10016



Maybe you don't want
your patients to halve Hygroton®chlorthalidone.



ybe your patients complain:
y don't they make a tablet I don't have to halve?"

s see brief prescribing summary at the end of advertisement.



Maybe you abandoned Hygroton chlorthalidone
because there wasn't a convenient half strength.

ns: Hypertension and many types of
volving retention of salt and water.

dications: Hypersensitivity and most
severe renal or hepatic disease.

With the administration of enteric-
tassium supplements, which should
only when adequate dietary supple-
is not practical, the possibility of
wel lesions (obstruction, hemor-
d perforation) should be kept in
gery for these lesions has fre-
een required and deaths have oc-
iscontinue enteric-coated potas-
lements immediately if abdominal
ention, nausea, vomiting, or gastro-
bleeding occur.

caution in pregnant patients, since
may cross the placental barrier and
actions which may occur in the
mbocytopenia, hyperbilirubinemia,
rbohydrate metabolism, etc.) are
roblems in the newborn.

s: Antihypertensive therapy with
should always be initiated cau-
ostsympathectomy patients and
receiving ganglionic blocking
ther potent antihypertensive drugs,
Reduce dosage of concomitant
nsive agents by at least one-half.
s, narcotics or alcohol may po-
otension. Because of the possi-
gression of renal damage, peri-
mination of the BUN is indicated.
e if the BUN rises or liver dysfunc-
ravated. Hepatic coma may be
d.

imbalance, sodium and/or potas-
ion may occur. If potassium deple-
occur during therapy, Hygroton
discontinued and potassium sup-
iven, provided the patient does
rked oliguria.

l care in cirrhosis or severe
art disease and in patients re-
ticosteroids, ACTH, or digitalis.
ion is not recommended.

ctions: Nausea, gastric irritation,
orexia, constipation and cramp-
ss, weakness, restlessness, hy-
, hyperuricemia, headache, mus-
orthostatic hypotension, aplastic
kopenia, thrombocytopenia,
osis, impotence, dysuria, transient
rashes, urticaria, purpura, nec-
iitis, acute gout, and pancreatitis
tric pain or unexplained G.I.
evelop after prolonged adminis-
r reactions reported with this
pounds include: jaundice, xan-
esthesia, and photosensitization.

age: One tablet with breakfast
y other day.

White, single-scored tablets of
aqua tablets of 50 mg., in bot-
d 1000. (B)46-230-D

ls, please see the complete
nformation.

aceuticals

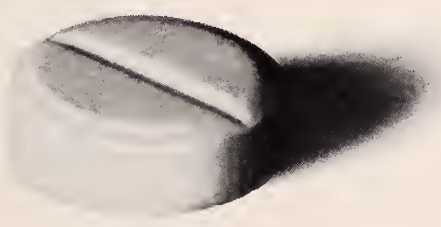
cal Corporation
York

Here's the Hygroton they don't have to halve



New Hygroton 50 mg. from Geigy

to go with the Hygroton 100 mg. you know



HY-5406

When the agitated geriatric disrupts the home...

His teen-age granddaughter won't invite friends home because of his outbursts.



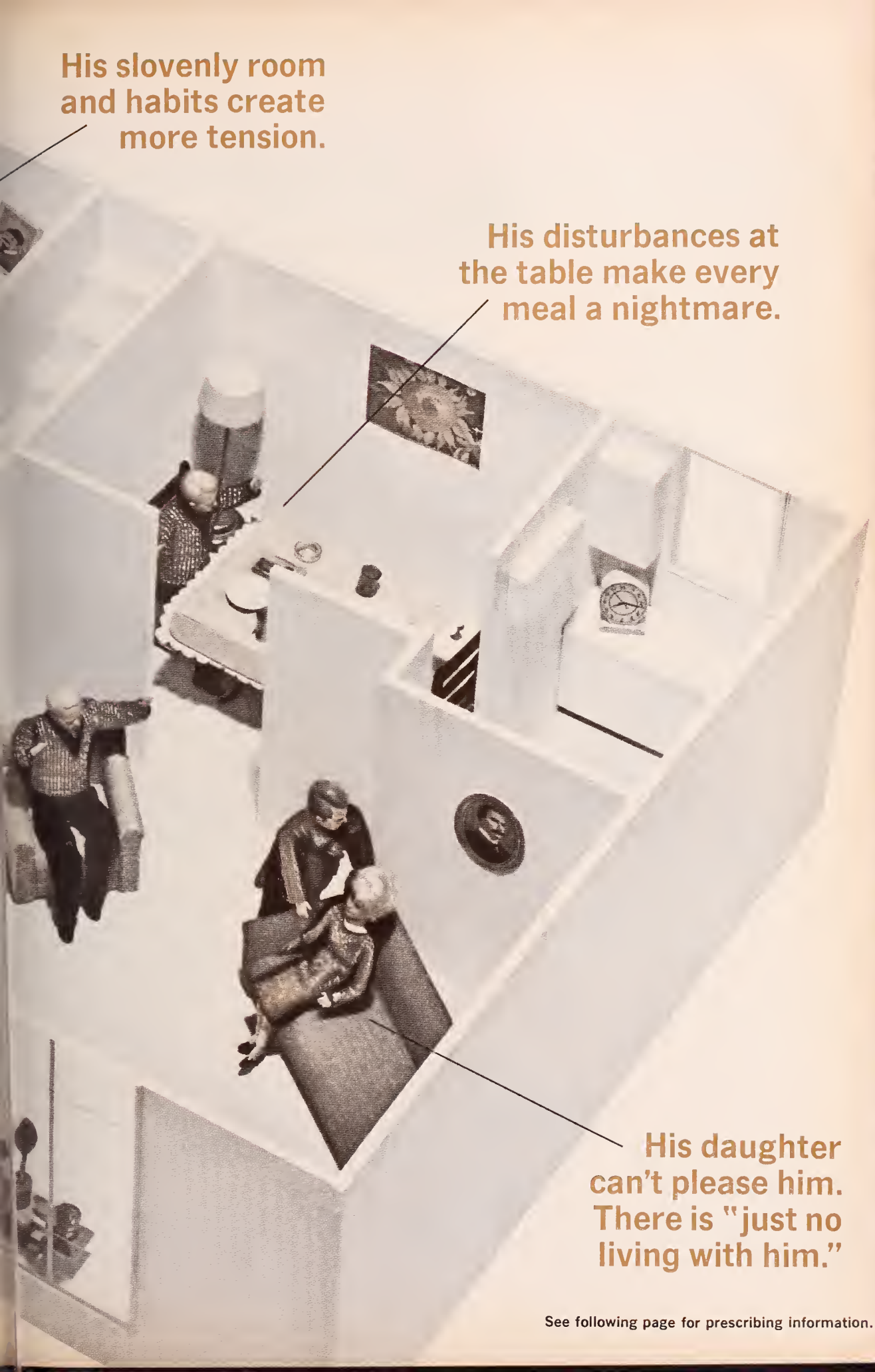
for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

SANDOZ

His slovenly room and habits create more tension.

His disturbances at the table make every meal a nightmare.



His daughter can't please him. There is "just no living with him."

See following page for prescribing information.

When the agitated geriatric disrupts the home...

Anxiety that seriously interferes with the individual's performance at work, at home, or in the community may be regarded as moderate to severe in degree.

Mellaril often recommends itself to the treatment of moderate to severe anxiety because it

- helps control the most frequent symptoms: marked tension, agitation, apprehension, restlessness, hypermotility
- often alleviates anxiety-induced somatic complaints
- frequently helps strengthen emotional resources
- helps the patient maintain realistic contact with environment, closer harmony with family

Thus, when you consider the anxiety moderate to severe... consider Mellaril.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

Before prescribing, see package insert for full product information.

for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

SANDOZ

mudrane®

for

- EMPHYSEMA
- ASTHMA
- CHRONIC BRONCHITIS
- BRONCHIECTASIS

The fast-disintegrating uncoated tablet gives relief in 15 minutes

Each tablet contains:

Potassium Iodide	195 mg.
Aminophylline	130 mg.
Phenobarbital, Caution: May be habit forming...	21 mg.
Ephedrine HCl	16 mg.

FEDERAL LAW PROHIBITS
DISPENSING WITHOUT PRESCRIPTION

Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

The AMBAR SCRAPBOOK of

Obesity Oddities

FACT & LEGEND

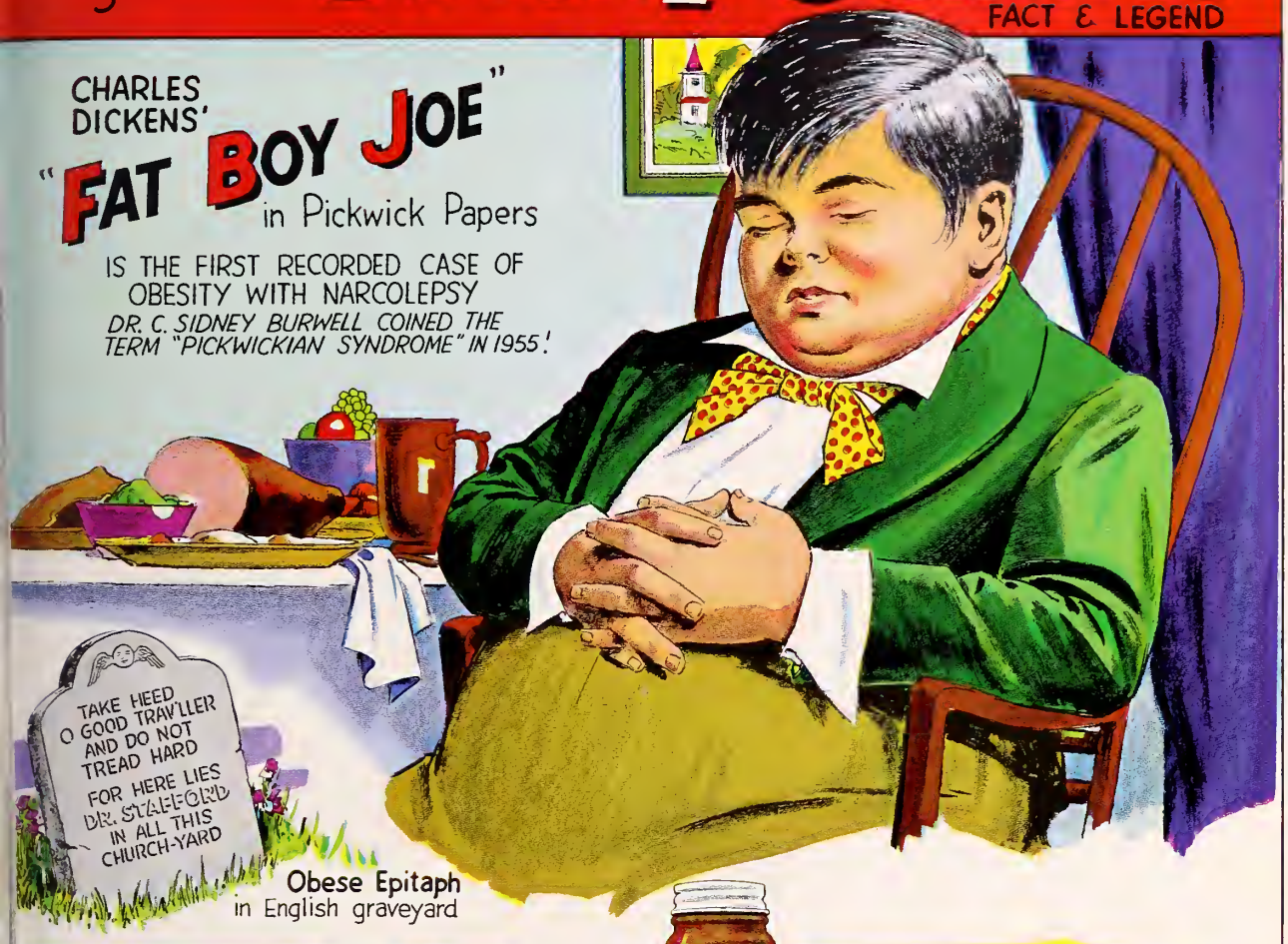
CHARLES DICKENS'

"FAT BOY JOE"

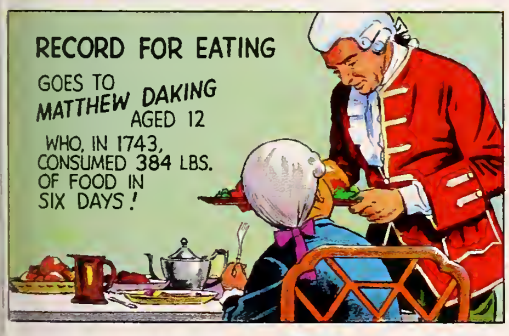
in Pickwick Papers

IS THE FIRST RECORDED CASE OF OBESITY WITH NARCOLEPSY

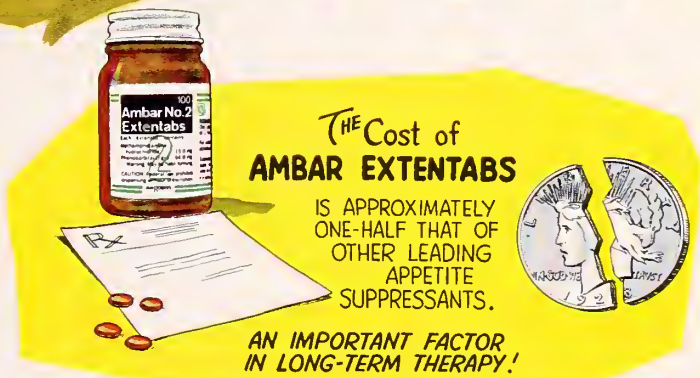
DR. C. SIDNEY BURWELL COINED THE TERM "PICKWICKIAN SYNDROME" IN 1955!



Obese Epitaph in English graveyard



RECORD FOR EATING GOES TO MATTHEW DAKING AGED 12 WHO, IN 1743, CONSUMED 384 LBS. OF FOOD IN SIX DAYS!



THE Cost of AMBAR EXTENTABS IS APPROXIMATELY ONE-HALF THAT OF OTHER LEADING APPETITE SUPPRESSANTS.

AN IMPORTANT FACTOR IN LONG-TERM THERAPY!

ONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

e Ambar Extentab before breakfast can
p control most patients' appetite for up
12 hours. Methamphetamine, the appe-
ti suppressant, gently elevates mood and
ps overcome dieting frustrations. Pheno-
bital, the sedative in Ambar, controls irritability and
iety...helps maintain a state of mental calm and equa-
ity. Both work together to ease the tensions that erode
willpower during periods of dieting.
o available: Ambar #1 Extentabs®—methamphetamine
rochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warn-
may be habit forming).

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220

A·H·ROBINS



Help clear up that miserable stuffed-up feeling with Dimetapp. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. The key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done... in a hurry.

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500

A.H. ROBINS COMPANY
RICHMOND, VA. 232
A·H·ROBIN

in sinusitis, colds, U.R.I.

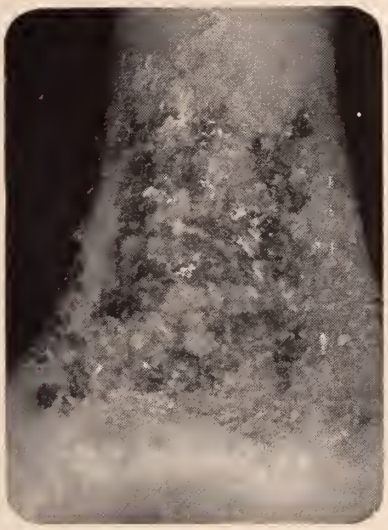
Dimetapp® Extentabs®

(Dimetane® [brompheniramine maleate], 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)

up to 10-12 hours clear breathing on one tablet



Eczema of many years... controlled in two weeks



Before treatment



After treatment—
with ARISTOCORT Topical
Ointment 0.1% for two weeks

ARISTOCORT® Triamcinolone Acetonide Topicals have proved exceptionally effective in the control of various forms of eczema: allergic, atopic, nummular, psoriatic, and mycotic.

In most cases responsive to topical ARISTOCORT, the 0.1% concentration is sufficiently potent. The 0.5% concentration provides enhanced topical activity for patients requiring additional potency for proper relief.

Administration and Dosage: Apply sparingly to the affected area 3 or 4 times daily. Some cases of psoriasis may be more effectively treated if the 0.1% Cream or Ointment is applied under an occlusive dressing.

Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

Available in 5 Gm. and 15 Gm. tubes and ½ lb. jars.

PHOTOGRAPHS COURTESY OF M. M. NIERMAN, M.D.

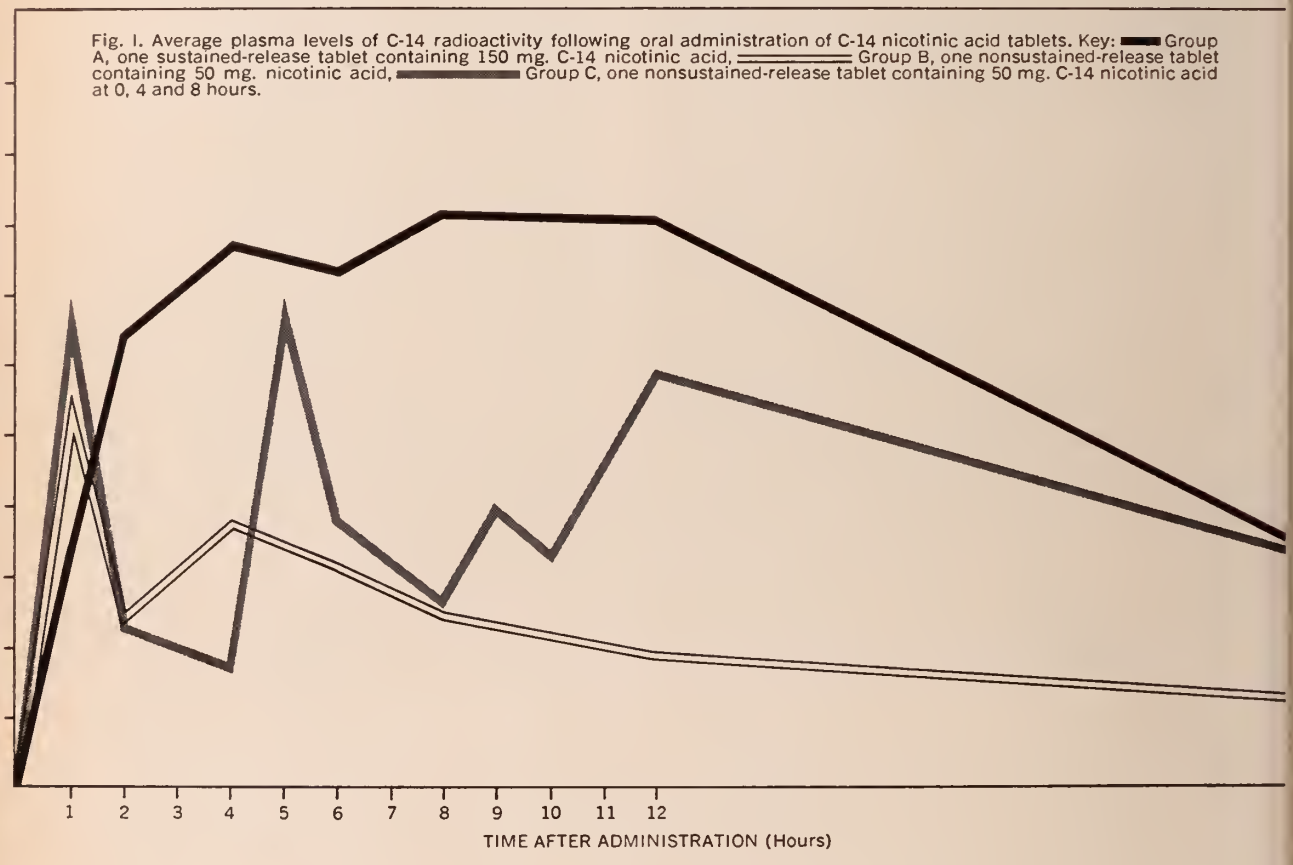
Aristocort® Topical Ointment 0.1% and Cream 0.1%, 0.5%
Triamcinolone Acetonide
Also available in foam form.

Lederle LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

406-6

Sustained circulatory, respirator
and cerebral stimulation for th

Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▬▬▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.





(fewer absent doses by absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be co tinuous on a daily dose of only one Geroniazol TT tab let every 12 hours.

The gradual release of nicotinic acid in Geroniaz TT will provide the well-known peripheral vasodilat tion needed in patients with deficient circulation an with a minimum amount (if any) of "flushing." Als cerebrovascular circulation is complemented by pe tylenetetrazol, long-established as a cerebral and re piratory stimulant.

Geroniazol TT improves the typical, unfortunat signs of senile confusion. Patients become more aler

ged and debilitated

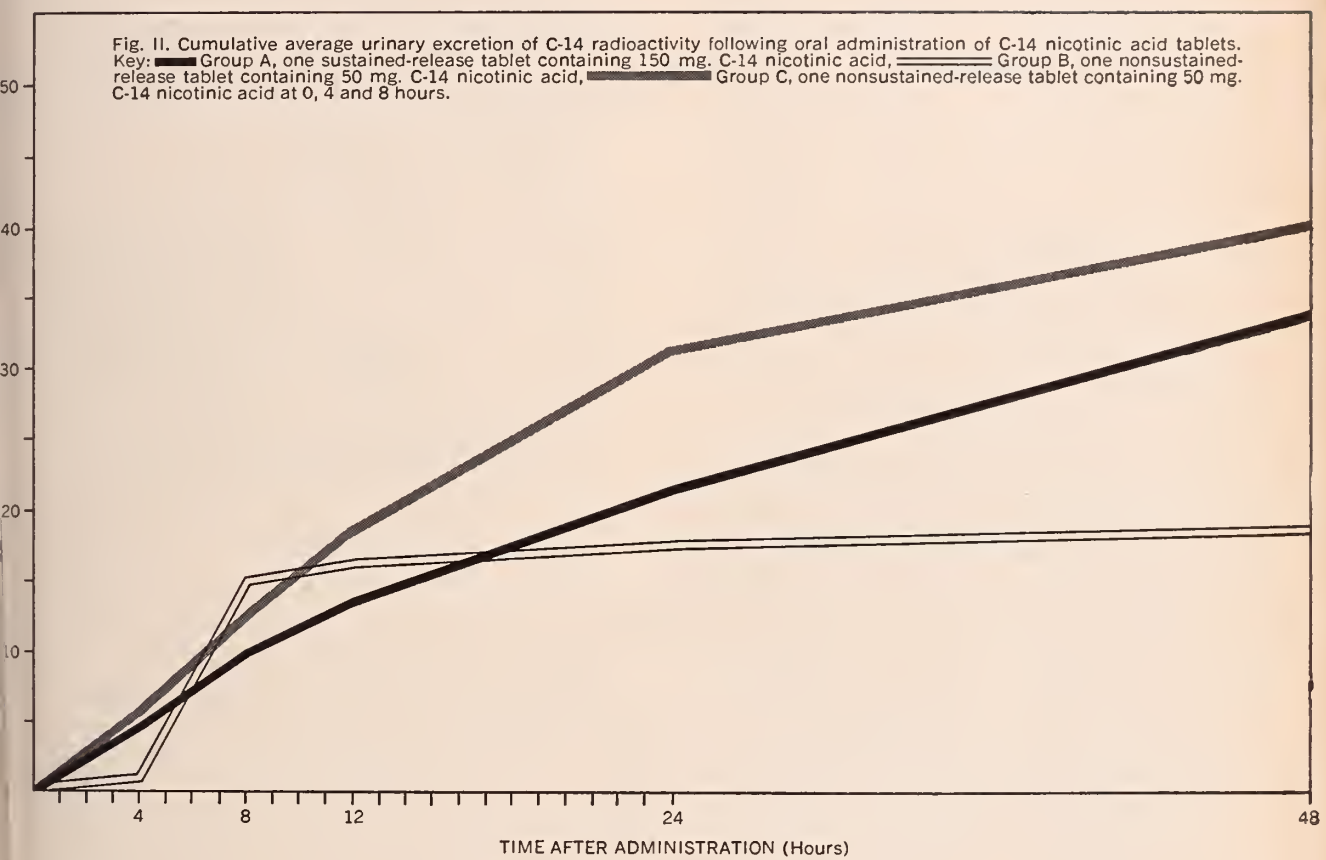


Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═══ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▬▬ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

confused and moody. Personal care, memory, tional stability, social attention improve. Fatigue, hy and irritability are reduced.

prescription for 100 tablets of Geroniazol TT will nit your patients to enjoy the benefits of time-onged nicotinic acid/pentylenetetrazol therapy, h economical price. Dosage is only one tablet every ours.

traindications: There are no known contraindica-s.

autions: Exercise caution when treating patients a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

"First with the Retro-Steroids"
PHILIPS ROXANE LABORATORIES
Division of Philips Roxane, Inc., Columbus, Ohio
A Subsidiary of Philips Electronics and Pharmaceutical Industries Corp.

Geroniazol® TT

nicotinic acid 150 mg., pentylenetetrazol 300 mg.
Tempotrol® Time Controlled Tablet

Diarrhea

TROCINATE® 400 MG.

BRAND THIPHENAMIL HCl.

The relief received from the first Trocinate 400 mg. tablet is so prompt that the discomfort of diarrhea ceases to be a bother. May be repeated every four hours.

Upon request, a supply of Trocinate 400 mg. with literature will be sent to physicians for their personal use.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

In Obesity, anorectic action with fewer unwanted side effects



CYDRIL®
(levamfetamine succinate TUTAG)



Cydril at 2 p.m. Appetite control at 6 Sleep at 10

Action and Uses: Cydril (levamfetamine succinate) is a chemopharmaceutical approach to aid the obstinately obese. Cydril (levamfetamine succinate) provides the appetite depressant action of amphetamines but exhibits fewer unwanted side reactions.

Dosage: Adults and 'teenagers', one (1) Cydril (levamfetamine succinate) Granucap* daily.

Side Effects: Occasionally cardiovascular and gastrointestinal reactions may produce dry mouth, metallic taste, anorexia, nausea, diarrhea, headache, chilliness, pallor or flushing, sweating, diuresis, and arrhythmias.

Contraindications: Cydril (levamfetamine succinate) should not be used in the presence of severe hypertension, angina pectoris, hyperthyroidism, and Raynaud's disease.

*Granucap is the Tutag brand of sustained release capsule manufactured to release the contents over a period of approximately 6 to 10 hours.

Caution: Federal law prohibits dispensing without prescription.

Full product information available on request or see page 1122 in your 1967 PDR.

For more about CYDRIL and the Cydril Family of Products ask the Man from Tutag (or your colleagues)

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DETROIT, MICHIGAN 48234

.i.d.

he sensible schedule
at covers the
atient day and night

ur objective in the use of a broad-spectrum antibiotic
longed action, with high blood levels, then you know
.i.d. DECLOMYCIN is considered to be a
le dosage schedule.

naintenance dosage of DECLOMYCIN
e kept at this convenient schedule
se of its unusually high effective blood
ssue levels.

.i.d. dosage of DECLOMYCIN gives you
mfortable assurance that the patient
l-covered, *day and night.*

nical practice, blood levels produced by
apeutic dose of DECLOMYCIN are
prolonged, and effective; because of
erum binding and slow renal clearance.
f there's a broader susceptibility
n of organisms, we've yet to see it.

is no need to give higher daily dosage
00 mg b.i.d., except in venereal diseases
aton Agent pneumonia.

ECLOMYCIN®
ETHYLCHLORTETRACYCLINE

ibing information on next page.

b.i.d. The sensible schedule that covers h patient day and nigh

DECLOMYCIN Demethylchlortetracycline sho d equally or more effective therapeutically tha tetracyclines when the offending organis tetracycline-sensitive.

Contraindication: History of hypersensiti demethylchlortetracycline.

Warning—In renal impairment, usual doses m to excessive accumulation and liver toxicity. Und conditions, lower than usual doses are indicated, therapy is prolonged, serum level determinations advisable. A photodynamic reaction to natural o cial sunlight has been observed. Small amounts and short exposure may produce an exaggerat burn reaction which may range from erythema t skin manifestations. In a smaller proportion, allergic reactions have been reported. Patients avoid direct exposure to sunlight and discontin at the first evidence of skin discomfort. Necessary quent courses of treatment with tetracyclines sh carefully observed.

Precautions—Overgrowth of nonsusceptible org may occure. Constant observation is essential. If fections appear, appropriate measures should be In infants, increased intracranial pressure with fontanels has been observed. All signs and sy have disappeared rapidly upon cessation of tre

Side Effects—Gastrointestinal system—an nausea, vomiting, diarrhea, stomatitis, glossitis, colitis, pruritus ani. Skin—maculopapular and ery tous rashes. A rare case of exfoliative dermat been reported. Photosensitivity; onycholysis a coloration of the nails (rare). Kidney—rise ir apparently dose related. Transient increase in output, sometimes accompanied by thirst (rare). sensitivity reactions—urticaria, angioneurotic anaphylaxis. Teeth— dental staining (yellow-bro children of mothers given this drug during th half of pregnancy, and in children given the drug the neonatal period, infancy and early chil Enamel hypoplasia has been seen in a few chil adverse reaction or idiosyncrasy occurs disc medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. mg b.i.d. Should be given 1 hour before or 2 hou meals, since absorption is impaired by the conc administration of high calcium content drugs. fo some dairy products. Treatment of streptococca tions should continue for 10 days, even though toms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 given in equally divided doses over a period of 10 to 15 days followed. Close follow-up observation of the patient is reco including appropriate laboratory tests, since demethylchlorte has not had adequate evaluation in all stages of syphilis. Sp examination should be included as part of this follow-up.

Acute gonococcal anterior urethritis in males has been treated with a single dose of 600-900 mg. of DECLOMYCIN Demethylc cycline. Individuals unable to tolerate large single doses due intestinal side effects may be treated with 150 mg. every 6 h minimum of 4 doses or 300 mg. every 12 hours for a minimum Females should be treated with a dosage of 150 mg. every 6 ho mg. every 12 hours until a cure is effected.

Primary Atypical Pneumonia (Eaton Agent): The average a dosage is 900 mg. in 3 divided doses for six days.

LEDERLE LABORATORIES, A Divisio American Cyanamid Company, Pearl Rive

Lederle

Dulcolax®

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w drugs work as predictably
Dulcolax. You can expect
at when your office patient
es Dulcolax at home, it will
as effective as you said it
uld be. Your patient will be
tified, too.

e reliability of Dulcolax
ms from its unique mode of
ion. The drug works
ectly on nerve endings in
colonic mucosa, producing
mal peristalsis throughout
large intestine. It does
rely on systemic absorption
its effect.

s reliable action provides
mpt relief of constipation.
so makes Dulcolax par-
ticularly useful for prepping the bowel for special procedures. In short, it makes Dulcolax ideal for your office practice.



Dulcolax acts so surely that the time of evacuation can often be closely predicted. Dulcolax tablets taken at night almost invariably result in a bowel movement soon after waking the following morning. Dulcolax suppositories generally work in 15 to 20 minutes, almost always within the hour.

Dosage Information: *Adults:* When an ordinary laxative effect
d, 1 to 3 tablets or 1 suppository usually suffices. Tablets
swallowed whole, not chewed or crushed, and should not be
hin one hour of antacids or milk. *Children:* 1 or 2 tablets,
g on age and severity of condition. Tablets must not be given
l too young to swallow them whole. For infants and children
ears of age, half a suppository is usually effective. Above this
ole suppository is usually advisable. Side Effects: As with any
abdominal cramps are occasionally noted, particularly in severely constipated persons. High dosage may result in loose, unformed stools. Contraindication: Contraindicated only in acute surgical abdomen. Availability: Tablets (5 mg.) and suppositories (10 mg.). By prescription or recommendation.

Under license from Boehringer Ingelheim G.m.b.H.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation, Ardsley, N.Y.

Geigy



"Yes, Doctor, the pain is gone."

'EMPIRIN'® COMPOUND with CODEINE PHOSPHATE gr. 1/2 No. 3

Each tablet contains: Codeine Phosphate gr. ½ (Warning – May be habit forming), Phenacetin gr. 2½, Aspirin gr. 3½, Caffeine gr. ½.

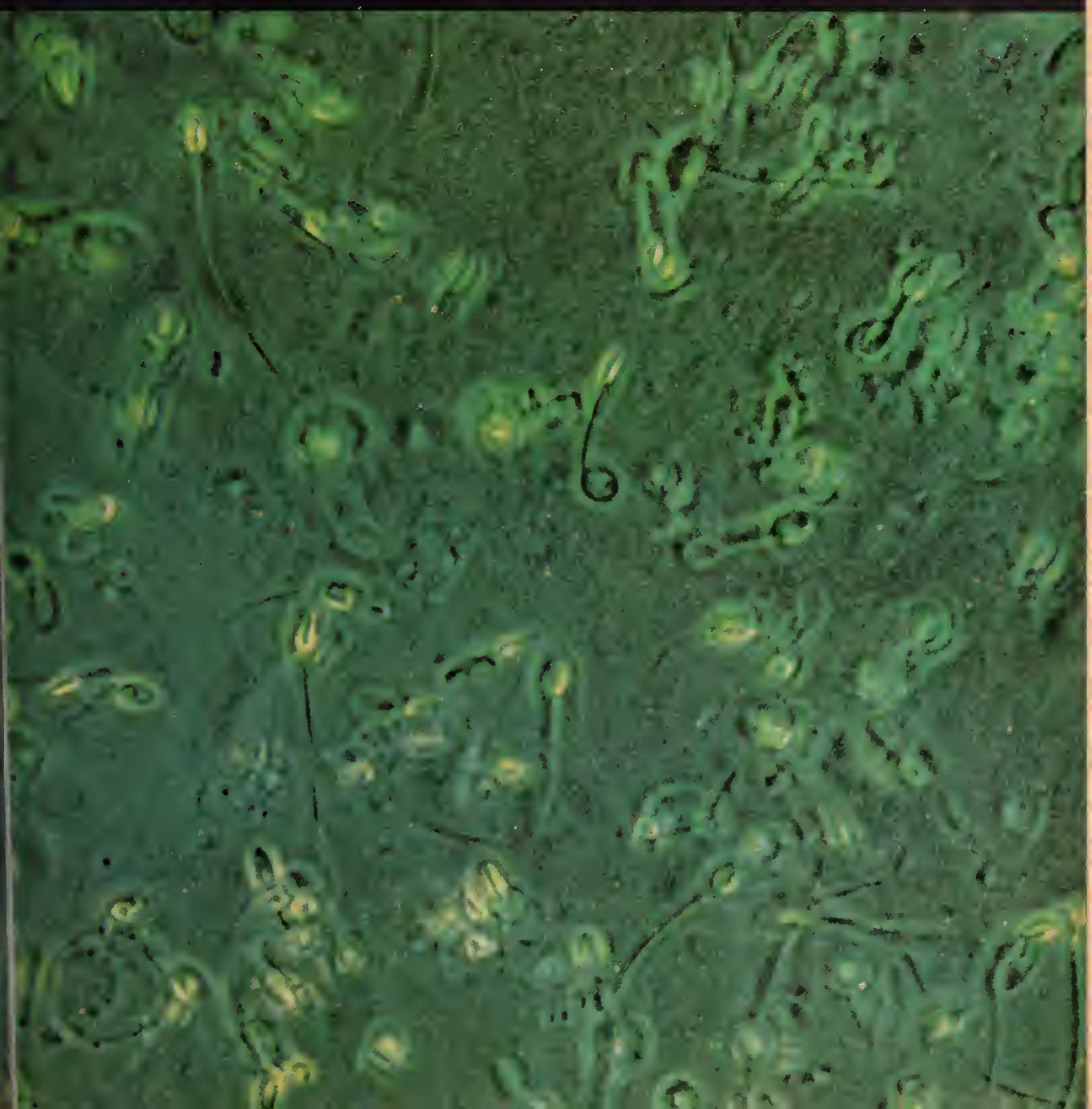
■ Despite introduction of synthetic substitutes, efficacy of 'Empirin' Compound with Codeine remains unchallenged.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg. c mestranol 0.05mg.)

Turn page for contraindications, precautions and side effects.



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Prescribing Information

Contraindications: Patients with any symptoms or history of thrombophlebitis, pulmonary embolism, liver dysfunction or disease, carcinoma of breast or genital organs, or undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. The safety of Norinyl-1 in pregnancy has not been demonstrated. If a patient misses two consecutive periods, pregnancy should be ruled out before continuing the medication. If she has not adhered to the prescribed schedule, pregnancy should be considered at the first missed period. Active ingredients of oral contraceptives have been detected in the milk of mothers who received these drugs; the significance to infants has not been determined.

Precautions: Pretreatment physical should include examination of the breasts and pelvic organs, as well as a Papanicolaou smear. If endocrine or liver function tests are abnormal during therapy, repeat tests are recommended after the drug has been withdrawn for two months. Following administration of drug, preexisting uterine fibromyomata may increase in size. Careful observation and caution are required for patients with symptoms or history of epilepsy, migraine, asthma, cardiac or renal dysfunction, cerebrovascular accident, psychic depression, and diabetes. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Possible long-term effects of the drug on pituitary, ovarian, adrenal, hepatic or uterine function must await further studies. The physician should be alert to the earliest manifestations of thrombophlebitis and pulmonary embolism. The drug should be used judiciously in those young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask symptoms of the climacteric. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following h
been observed with varying ir
in patients receiving oral cont
tives: nausea, vomiting, gastr
tinal symptoms, breakthrougl
bleeding, spotting, change in
menstrual flow, amenorrhea,
chloasma or melasma, breast
(tenderness, enlargement and
secretion), change in weight (i
or decrease), changes in cervi
erosion and cervical secretion
suppression of lactation when
immediately postpartum, cho
jaundice, migraine, rash (alle
rise in blood pressure in susce
individuals, mental depressio
Although the following side e
have been reported in users o
contraceptives, no cause and e
relationship has been establis
anovulation posttreatment, p
struallike syndrome, changes
libido, changes in appetite, cy
like syndrome, headache, ner
ness, dizziness, fatigue, backa
hirsutism, loss of scalp hair,
erythema multiforme, erythe
nodosum, hemorrhagic erupti
itching. The following occurre
have been observed in users o
contraceptives (a cause and ef
relationship has neither been
lished nor disproved): thromb
phlebitis, pulmonary embolis
neuroocular lesions.

The following laboratory test
be altered by the use of oral c
ceptives: increased sulfobrom
phthalein and other hepatic fu
tests, coagulation tests (increa
prothrombin, factors VII, VIII
and X), thyroid function (incr
PBI and butanol extractable p
bound iodine and decrease in
values), metyrapone test, preg
nanediol determination.

norethindrone — an original steroid from

SYNTEX

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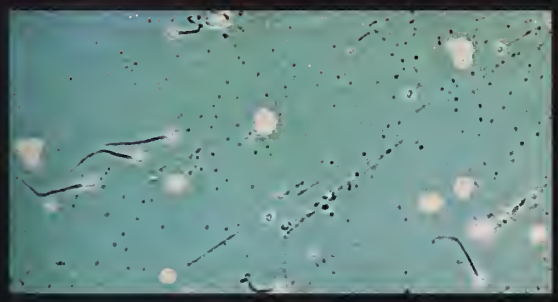
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

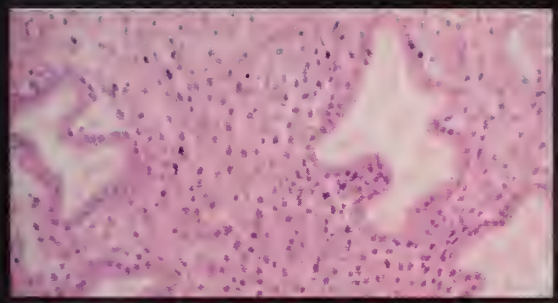
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.



Spermatozoa appear healthy, active, freemoving.

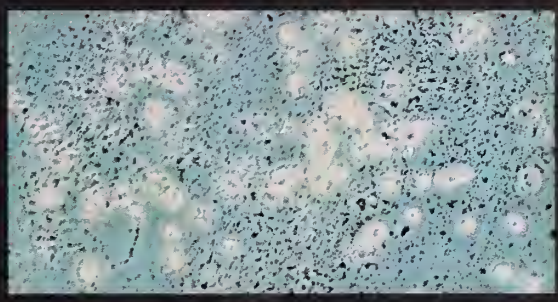


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

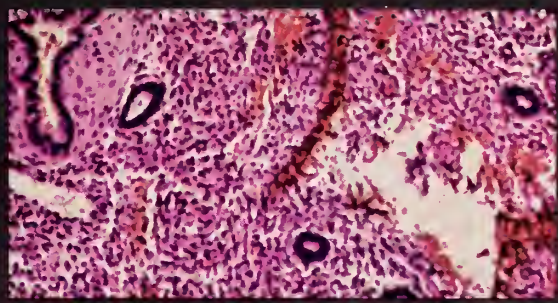
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



Norethindrone in Norinyl-1 accelerates secretory phase, suppresses glandular and vascular development.

Norinyl®-1 tablets
(norethindrone 1mg c mestranol 0.05mg.)

- new low dose of time-proved ingredients
- established norethindrone/mestranol ratio
- lower patient cost

An uncommon steroid for common inflammatory dermatoses

In everyday topical steroid therapy, Synalar produces rapid resolution of inflammation and itching in steroid-responsive dermatoses—and at relatively low cost to the patient.

Advanced molecular design enhances potency

Synalar combines the advantage of earlier corticosteroid compounds with unique structural innovations. As a result, preparations of Synalar 0.01% and Synalar 0.025% have been reported to be more potent topically and significantly more effective than hydrocortisone 1.0%. The unique fluocinolone acetonide molecule provides one of the most useful topical corticosteroids for everyday practice.

Impressive clinical results in a wide range of dermatologic problems

The clinical efficacy of Synalar has been extensively documented in the world literature. Commonly encountered diseases such as allergic and contact dermatitis, eczematous and seborrheic dermatitis, and neurodermatitis respond rapidly to Synalar, often where previous therapy with oth topical corticosteroids has failed

Low patient cost for wider usefulness

With Synalar, a high degree of efficacy does not mean high pric And—a small quantity goes a lo way. Thus, your patients can often obtain the "economy" of a hydrocortisone preparation with the proved efficacy of a potent, truly advanced steroid.

Synalar

fluocinolone acetonide





Turn page for contraindicat… …cautions and side effe…

For everyday topical steroid therapy

Synalar® 0.01%

fluocinolone acetonide provides economy in two practical dosage forms

For general use, the most economical and widely applicable concentration of Synalar is 0.01% Cream in a water-washable, vanishing cream base. Synalar Solution 0.01% is especially valuable in dermatoses involving moist, intertriginous areas or hairy sites where creams and ointments do not spread or penetrate readily. Synalar Solution is a unique dosage form—clear, nongreasy, cosmetically elegant.

Product Information

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. *Precautions:* Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. *Side Effects:* Side effects are uncommon with topical corticosteroi As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. In such cases the agent should be discontinued and appropriate measures taken. *Availability:* Synalar (fluocinolone acetonide) Cream 0.025%—5, 15 and 60 Gm. tubes and 425 Gm. jars. Cream 0.01%—15, 45 and 60 Gm. tube and 120 Gm. jars. Solution 0.01%—20 and 60 cc. plastic squeeze bottles. Ointment 0.025%—15 an 60 Gm. tubes. Neo-Synalar® (neomycin sulfate 0.5% [0.35% neomycin base], fluocinolone aceton 0.025%) Cream—5, 15 and 60 Gm. tubes.

fluocinolone acetonide—an original steroid from

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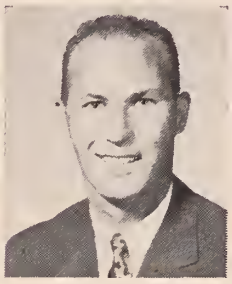
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In New Jersey . . .
These Syntex men serve the physician



Richard Becker
N. Brunswick, N. J.
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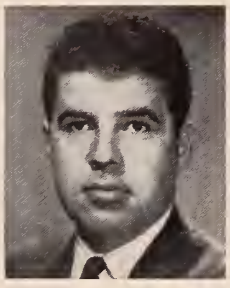
John Boyle
Clark, New Jersey
381-6892



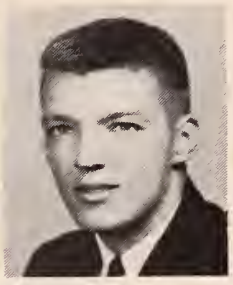
John Leahy
Cinnaminson, New Jersey
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Patrick McGlynn
Little Falls, New Jersey
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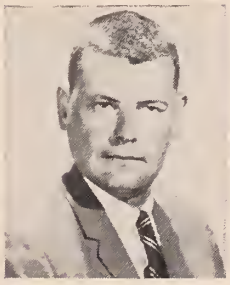
Louis Molluso
Oakland, New Jersey
337-4940



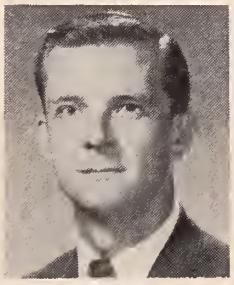
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Yeadon, Pennsylvania
259-4072



Robert Petruzzo
Blue Bell, Penna.
646-1671



Roger Reeder
Margate City, N. J.
822-7013



John Stemplinger
Fairlawn, New Jersey
791-2568

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LABORATORIES INC. PALO ALTO, CALIF



"George wants to know if it's okay to take his cold medicine now, Doctor, instead of seven o'clock?"



The long-continued action of Novahistine LP should help you both get a good night's sleep. Two tablets in the morning and two in the evening will usually provide round-the-clock relief by helping clear congested air passages for freer breathing. Novahistine LP also helps restore normal mucus secretion and ciliary activity—normal physiologic defenses against infection of the respiratory tract. Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result. Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

NOVAHISTINE® LP

DOW **PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis

easy does it!

tear, moisten, compare–that's all!



EDITORIALS

Physician-Volunteers For Viet Nam

Some of our activities in the past few years have been targets for criticism. The result has been an alleged eroding of the "image" of the American physician. Somehow, the socially more significant of the profession's activities have never been given equal time. One of the little-known projects has been the AMA-sponsored program of M.D. volunteers for Viet Nam. On page 624 of this issue we publish an account of that enterprise. It has certainly been one of the most successful elements of the United States civilian assistance program.

Why should any doctor volunteer? Not certainly for money, since all he can get is an expense allowance of $10 a day. Not because it will be a comfortable haven. It really isn't. Not to get a free trip to the world's glamor spots, since there are safer ways of doing that, and a more varied itinerary can be furnished by your friendly, neighborhood travel agent. But there is a sense of doing something desperately needed to help unfortunate women, men, and children in a war-torn, much underdoctored country. For those physicians who have volunteered (one out of every thousand), the experience has been so satisfying as to motivate a number of them to return for a second tour of duty.

One notes, with some embarrassment, that New Jersey has only two names on this honor roll — Dr. S. William Kalb and Dr. Francis E. Gilbertson. By contrast with our list of two, there are states with half as many M.D.s as New Jersey, who have supplied two or three times as many physician-volunteers. Some states, less populous than ours, have supplied as many as 11 (Indiana), 12 (South Carolina), and 15 (Washington).

You And The WMA

You are now eligible for individual membership in the World Medical Association. Dues are ten dollars per year. This includes a subscription to *World Medical Journal* and the privilege of participation in the World Medical Assembly each year. This year's Assembly (the 21st) was held in Madrid, Spain.

The World Medical Association, organized in 1947, is a society for the professional medical associations of the free nations. Sixty national medical associations are members, including the AMA. These associations represent more than 700,000 physicians — a majority of all scientifically trained physicians in the world. Gerald D. Dorman, M.D. of New York, a member of the AMA Board of Trustees, is chairman of the Council, the governing body of the WMA. The WMA Headquarters Secretariat is located at the Columbus Circle, New York, New York. Secretary General is Alberto Z. Romualdez, M.D.

Application for individual membership may be made in the form of a letter to the New York office. Applications should be accompanied by a check for ten dollars, with a statement that the applicant is a member in good standing of the AMA. The letter should specify whether the applicant wishes to receive the *World Medical Journal* in English, Spanish, or French. Five-year memberships are available for fifty dollars. Checks should be make payable to The World Medical Association, Incorporated. WMA is a tax-exempt organization. Funds donated to the organization are tax-deductible.

"The World Medical Association," said Dr. Dorman, "is uniquely qualified to act as a force for peace and understanding in the world today. WMA is a very real and vital part of the world health picture, continually seeking to solve world medical problems through the community spirit and action of its professional membership." WMA has no connection with any government. It is committed to the philosophy that medical and scientific knowledge should be universally

available and free of all political control. The WMA is present at conference tables around the world where decisions are made affecting the practice of medicine, and where the practicing physician's free-enterprise viewpoint would not ordinarly be considered. Thanks to WMA, the individual doctor has an effective, recognized international voice in health and professional matters now being considered by such government organizations as WHO. UNESCO, International Labor Organization, International Social Security Association, and other governmental and nongovernmental bodies.

The World Medical Association has become a strong factor in protecting and promoting the professional interests of the medical professions and the cause of world peace, and deserves your interest and participation in its work. Doctors of medicine the world over cherish the same basic ideals of conduct and the same devotion to the welfare of mankind. WMA is cultivating the common purposes of the profession. This growing community of interest is a source of strength to the physicians in every land. By solid accomplishments in the fields of medical education and ethics, the World Medical Association has earned the right to call itself the "international voice of organized medicine." Everywhere we find physicians striving to preserve or — where they have lost it — regain their freedom to practice medicine according to the dictates of their consciences and their scientific disciplines.

The present and potential benefits and achievements of WMA should entlist the support of American doctors who will wish to participate in such projects as:

Establishing self-sustaining rural medical aid units in developing counties;

Providing professorial exchange programs between well established and new medical faculties;

Administering scholarship funds within the ethnic regions of the world;

Providing an efficient medical information exchange center;

Implementing the 4th World Conference on Medical Education — a world dialogue on "Medical Education — A Collective Responsibility."

WMA engages in many activities the year around which contribute to a better understanding among the people of the world. WMA assists traveling physicians by providing them with introductions to colleagues in other countries, by informing them of medical meetings they may attend while abroad, by acquainting them with visiting doctors from other countries, and, of course, by providing the *World Medical Journal* and announcements relative to the Annual Assemblies which these members may attend as official observers. Future Assemblies are scheduled in the following venues:

Sydney, Australia	August 5-10, 1968
Paris, France	June 15-22, 1969
Toronto, Canada	September 13-17, 1971
Amsterdam, Netherlands	August 1972
Koln, Germany	August or September 1973

The World Medical Association is best known for its organization and sponsorship of three World Medical Education Conferences (London 1953, Chicago 1959, and New Delhi 1966), which resulted in the first comprehensive textbooks on world medical education. It also publishes *World Medical Periodicals,* a standard guide for scientific writers, medical editors, and librarians.

Activities in the field of medical ethics have resulted in the world renowned and accepted Declaration of Geneva, a modern restatement of the Hippocratic Oath; an International Code of Medical Ethics, adopted in 1948-1949 and the Declaration of Helsinki (1964) — Recommendations Guiding Doctors in Clinical Research.

Nor has the WMA been remiss in the field of socio-medical legal affairs. In 1948, it adopted twelve basic principles to goven medical care in social security programs. It endeavors to counter efforts on the part of the social security agencies to eliminate the rights and privileges of the patients and the doctors in

receiving and delivering medical care. As recently as 1963, these Twelve Principles were reviewed and amended to strengthen their application to changing world practices. In 1964 WMA adopted a series of Recommendations Concerning Medical Care in Rural Areas.

The World Medical Association, the first nongovernmental agency recognized for liaison with the World Health Organization — the official health agency of the United Nations, has served the profession by speaking for it at World Health Assemblies and other international organizations considering medical and health problems. The relationship of WMA with WHO and other governmental agencies tends to be friendly and constructive.

America's world leadership in medicine challenges American physicians to make the World Medical Association a truly impressive and effective representation of the American doctors' interest and concern in the welfare of this world. As the international voice of organized medicine, WMA is speaking for you. It is seeking to promote and protect your interests. Help these efforts by becoming a member and participating in its work.

November Is Life Month

This is the seventh annual life month for The Medical Society of New Jersey Life Insurance Plan. During this month, members under age 65 are invited to apply for life insurance under this State and County Society approved plan.

More than 1700 of our members participate in the program and actual claim payments to beneficiaries exceed $1,200,000. One of the member-policyholders who died during the past year had five units of coverage and $50,000 was paid to his beneficiary. The low cost, high quality, and generous limits of the society's life insurance plan make it possible for members to make their life insurance program more adequate. Increased life insurance protection is generally required when your income has increased, your standard of living improved, your responsibilities grown, or your cost of living has gone up. The low net premium of the Society's program keeps the cost of this valuable coverage so low that members can afford to build an adequate insurance program.

Up to ten $10,000 units of term life insurance are available, making the maximum life insurance protection $100,000. The double indemnity provides up to an additional $100,000 for accidental death. There is no extra premium cost for the waiver of premium benefit, double indemnity for accidental death, and guaranteed right of conversion to whole life insurance without physical examination.

Complete information is being sent members by the administrator, E. & W. Blanksteen Agency. Possibly you have already received your letter in the mail. For personal help and information, you may call the agency collect at (201) DE 3-4340.

Publish Or Perish

There is no point in making a medical discovery, accomplishing a successful research plan, or inventing something useful if the information remains locked in the files. Crawford Long may have been the first to use ether as an anesthetic in surgery, but Dr. Long appears to have made no effort to publicize his remarkable achievement. So modern anesthesia began with the Morton-Wells-Jackson efforts in Boston. Their method and the results were swiftly published; and the history of surgery moved on to a dramatic new track.

In the hospitals and clinics of our land, the wealth of clinical "material" (if human beings may be properly classed as "material") provides a gold mine of data available to anyone who has the ingenuity and the persistence to tap that mine. Lurking somewhere, perhaps in the back wards of hospitals, perhaps in the file cabinets of "chronic" public

clinics, are data out of which may be fashioned the ultimate key to many mysteries of medicine.

The thinking of one mind stimulates the thinking of another. One worker's ideas can set fire to another worker. But none of this is possible unless the results are published so that other scholars can see them and read them. Didacus Stella once said, "Pygmies on the shoulders of giants see more than the giants can see." What one observer reports can provide the shoulders on which another (and even a lesser) observer can stand. But first the findings must be published—or at least read at a meeting. Oral words, though, are too ephemeral to provide a solid base for further exploration. The findings must be published so that other workers can take them from there.

When cynics make fun of the "publish or perish" dictum, let this be remembered: unless, in today's world, someone publishes, medical progress will indeed perish.

Sing No Requiem For Private Health Insurance

Certainly, Government has become increasingly involved in programs to meet the costs of sickness. However, R. M. Defossez* recently pointed out that the severely limited extent of some federal programs, plus gaps in the coverage actually make the need for private insurance (by itself or as a supplement) more apparent.

Social insurance is here to stay, so the effort in dealing with it must take the form of enveloping it with complimentary and supplemental coverages so that the insured public will have the choice of providing themselves with a complete package of protection.

Social insurance programs include workmen's compensation; disability benefit insurance; Medicare; Social Security disability benefits; Medicaid; Social Security medical, hospital, and surgical benefits; and the benefits provided under Title XIX.

The benefits provided under these programs are often not enough to meet the cost of care and loss of income. Private insurance has been able to market coverage in some of the above areas to bring the total benefits up to a realistic level. Group coverage, sold mainly to employee groups, is usually not very expensive. Some employers have not provided their employees with coverage, but the persistence of both the health insurance companies and the unions is narrowing the gap all the time.

Salary continuation programs ("loss of income" policies) are now popular. But the greatest challenge to private insurance has been Medicare. Some insurers had been slow to recognize and meet the needs of senior citizens for hospital and medical insurance coverages. If companies had responded sooner to this fact of life, Medicare legislation might not have been needed.

Industry soon realized it was not completely shut out of the market. Programs can be designed which would be of value and practical use to elderly persons in conjunction with Medicare.

No program of social insurance in the health field occupies its particular sector so completely that there is no room for private coverage. A definite need for private insurance remains. This will increase, since benefits provided through statutory processes cannot keep pace with an inflationary economy as readily as can those provided by non-statutory means. Let us hope that the response to the needs of the American public by the health insurance companies will be prompt and vigorous in the future, making further legislation unnecessary.

* Mr. Defossez is general counsel to the Continental Casualty Company. These ideas were culled from a talk that Mr. Defossez gave last summer at the meeting of the American Bar Association.

ORIGINAL ARTICLES

Keloids are often resistant to treatment. Dr. Goldberg here suggests several patterns of double barrelled attack on these stubborn lesions.

Combined Modalities In The Treatment Of Keloids*

Harry C. Goldberg, M.D./Plainfield

There is some evidence that keloids were described in the Smith papyrus about 1500 B.C. The first clear description was given by Alibert[1] in 1806. The word *keloid* was introduced by Addison in 1854 although the lesions he described were not (scleroderma).[2] Keloids are benign, proliferative, fibrous outgrowths, having their origin in the subpapillary layer of the dermis. They develop as a result of trauma in certain predisposed individuals.[3] Some question concerns the differences between hypertrophic scars and keloids.[4] The histologic distinction can be made with a significant degree of accuracy. Blackburn and Cosman[5] state that histologic examination of keloids shows conspicuous collagen bundles, abundant mucinous ground substance, occasional fibroblasts, and an absence of foreign body reaction, whereas hypertrophic scars show opposite characteristics. They found in their series of 163 lesions that over 60 per cent of keloids recurred, compared with only 10 per cent recurrence of hypertrophic lesions.

Etiology

Koonin[6] mentions trauma, increased skin tensions, foreign-body reaction, age, race, sex, heredity, constitutional factors, infections, and endocrine causes. Bloom[7] reports an interesting familial series of multiple keloids in five generations. Garb and Stone[8] in 1942 reviewed the literature, reported 80 cases and list chiefly X-ray therapy and surgical methods in treatment, though they also mention internal medications, topical applications, and physiotherapeutic methods. They refer to keloids occurring at the site of electrolysis treatments for superfluous hair, at the site of red (but not the green) tattoo in one individual, and the frequent (sad and so unnecessary) formation at the site of pierced ears. No really new changes in therapy occurred until the steroids were developed and were used topically and by injection for treatment of keloids. This is summed up, after a decade, in 1964 in the French literature by Wechsler.[9] An article as early as 1954 was written by Griswold[10] on the effects of adrenal cortical preparations on scar hypertrophy.

Therapy

Garb and Stone[8] in 1942 said that roentgen rays and radium were the only effective treatment for keloids although they cited one patient with two keloids which did not respond to over 6000 R (today ⅓ of this amount is considered in the top range of safety). Most of their patients received about 3000 R. They reported a 25 per cent cure rate. Bromberg[11] wrote in 1963 that he had consistently effective results using 1500 R within 7 to 10 days (500 R increments) after keloidectomy. His letter (November 9, 1966) in response to my inquiry stated he had not collected further data but added that his recommended dosages

* Read before the Section on Dermatology, Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 17, 1967. This work was supported in part by a grant from Merck, Sharp and Dohme Research Laboratories. Dr. Goldberg is Chief of Dermatology, Muhlenberg Hospital, Plainfield.

are usually effective. Roswit[12] stated during a panel question and answer period in a query by Goldberg on the use of X-ray therapy on keloids, "Don't." One of the confusing factors in evaluating the effect of X-ray therapy is the size of the area involved. This has been worked out for small areas by Goldberg.[13] X-ray therapy will be discussed further in connection with my own patients.

New corticosteroid preparations were developed and new ways and methods of using these paralleled them.[14] This article is partly concernd with the use of dexamethasone phosphate and dexamethasone acetate for intralesional use.† This is a rapidly and slowly absorbed combination of dexamethasone to provide a maximum immediate as well as a prolonged corticosteroid effect on keloidal tissues. My own early experience with the injection of these lesions usually resulted in a large pool of the corticosteroid in or under the keloid. Little good was obtained and a sterile or infected abscess often resulted. McGuire[15] reported a sensational result obtained by injection of a large keloid with multiple doses of triamcinolone acetonide over a 22 month period. This is not without its dangers and these (chiefly atrophy, secondary infections, and hypersensitivity) were described by Goldman[16] in 1962. Further studies in this direction were done by Mancini,[17] Murray,[18] and Griffith.[19] This method was also combined with surgery and X-ray. The injection technic usually was to do a local block anesthesia of the keloid and then inject the corticosteroid drug in a fan-wise distribution through one or several ports. It is believed that it may interfere with fibroplasia by diversion of amino acids from protein synthesis to carbohydrate formation.[14] Ketchum, *et al*[21] stated that bioassay confirmed the clinical picture by showing consistent increase in the solubility of the collagen of the hypertrophic scar following intralesional injection of triamcinolone. Bernstein[22] discussed the role of biochemical tests in the diagnosis and prognosis of keloids, using the sedimentation rate, the Weltman (sero-coagulation test), and gamma globulin paper strip electrophoresis. He reported good results especially in hypertrophic scars following surgery, by the use of oral corticosteroids as well as intramuscular, and intralesional corticosteroid injections. An unusual method utilizing thio-tepa (a chemical antimitotic) for injection was reported by Fischl.[23] He reported encouraging results. I have used this occasionally but with disappointing results. Among other exotic therapies, podophyllin ointment was applied to the base of one keloid after cutting it flat. The podophyllin[24] has colchicine-like effects, and arrests cell mitosis in the metaphase. No improvement was noted.

Patients often have multiple keloids. Whereas the treatment of one is difficult, the removal of many often appears hopeless. Dry ice and skin grafting may be added to the methods already noted.

For several years I have used a method which offers simplicity and practicalness in the treatment of single, and especially multiple keloids. First, gentian violet is painted along the periphery of the keloid to outline the extent of the area to be cut off. The skin around the keloid is injected with lidocaine containing epinephrine as a nerve block. None is injected into the keloid, but it may also be injected under the keloid for complete anesthesia of the keloid. It is important to slice off the keloid at its periphery and not outside of it. The removal of the elevated portion of the keloid is easily accomplished with a double-edged razor blade. It is superior to most surgical knives for this purpose. The brittle old type carbon steel razor blade is best and this is snapped into two parts. These in turn are snapped into appropriate lengths. A good length of razor blade to use is about twice the width of the keloid. The blade is held in a conveniently sized suture holder or hemostat and is used with a sawing motion. The keloid is held so that it bulges upward slightly and is easily sawed off at the gentian violet markings. Bleeding is controlled with 100 per cent trichloracetic acid solution, or a 15 per cent ferric chloride solution (beware of staining on normally exposed skin areas), electro-desiccation, and/or pressure. The exposed base of

†Dexamethasone phosphate/acetate 2/8 supplied by Merck, Sharp and Dohme Research Laboratories.

the keloid is now treated somewhat as a greenskeeper might plug his greens. A very sharp 25 gauge (disposable type) needle is used to plug the corticosteroid repository suspension into the lesion with a 3 or 5 milliliter Luer-Lok® syringe (to obtain maximal pressure). These sharp needles are readily pushed into the hardest keloids. It may be difficult to inject much of the solution into the hard portion of the keloid. Often, indeed this is more of a kernel than complete involvement of the cut off area. It is however practical to leave an effective amount of the corticosteroid suspension through-out the keloid because of the method of injection. The needle is injected directly into the surface of the keloid at two or three millimeter point distances until the entire surface has been penetrated and injected. The solution is gradually injected while pushing the needle into, through, and beneath the keloid. It is easier *not* to use the needle in a fan-like distribution. Good results have been obtained with a dexamethasone phosphate/acetate 2/8 suspension. Two to four milliliters of the solution are injected depending on the size of the keloid to be treated. Although, the newer repository suspensions are gradually absorbed, the older type remained almost indefinitely. I have in one instance curetted out the heavy deposits made in the intralesional treatment of a different kind of skin problem, when it was clear that excessive atrophy had developed and that further skin changes would continue. My earlier results with this method at first seemed good with a single saturation of the keloid. As time revealed frequent recurrences, it was found necessary to repeat the injection of the keloid. The dexamethasone phosphate/acetate 2/8 suspension is completely absorbed in 30 days.[25] For this reason the keloid should be reinjected several times at 2 to 4 week intervals until no further raising of the keloid develops.

Case One

A white child age 9 developed a keloid (hypertrophic scar) five months after the removal of a benign nevus on the back of the lower thigh. This responded reasonably well to seven dry ice applications and two injections of dexamethasone phosphate/acetate 2/8 suspension, given over a one year period.

Case Two

This patient had large tattoos on his forearms and arms. He insisted that every particle of pigment be removed. This was accomplished by dermabrasion and snipping out the remaining pigmented area. A keloid (hypertrophic scar) resulted. Because of the large areas involved and the lack of interest by the patient, no treatment was instituted.

Case Three

This young man had a tattoo of the forearm removed by an old technic, namely, introduction of tannic acid solution by tattooing and the application of silver nitrate. This was followed by a keloid. X-ray therapy was given without any important improvement.

Case Four

A 7-year-old child developed a keloid (hypertrophic scar) several months following a fall which caused a laceration of the knee. It was treated by cutting level the hypertrophic scar and injecting it with the dexamethasone phosphate/acetate 2/8 suspension. This recurred rapidly. Further treatment was given with dexamethasone suspension injections and dry ice applications. This has given only a slight improvement during a four month period of treatment. The patient was not seen for further care.

Case Five

The removal of a nevus on the upper arm was followed by a keloid two months later. This was treated two years later by cutting it level, skin grafting and then injecting the keloid with dexamethasone phosphate/acetate 2/8 suspension. To date this result has remained satisfactory.

Case Six

This 5-year-old Negro girl developed marble sized keloids of the ears, three years after they had been pierced for earrings. Two years after the keloids had developed they were cut level and injected once with dexamethasone phosphate/acetate 2/8 suspension. The keloids have since recurred. Lack of follow-up (due to moving of the patient) has prevented careful attention. Contact has been made with the parents and it is planned to redo these soon.

Case Seven

A 25-year-old Negro had keloids of the sternum which were present for years. The combined modalities mentioned were used repeatedly. The surgical procedures used were both of the cutting level type and of complete excision of the lesions. Three recurrences developed after these procedures. The final results were worse than the initial lesions.

Case Eight

A 17-year-old white boy had a small keloid of the chest. This was treated by a corticosteroid injection after being cut flat. It recurred several months later.

Case Nine

This patient had 18 keloids. Fourteen have been treated. He has been unusually cooperative and many different kinds of procedures have been utilized in his care. Most of his keloids were treated by cutting the

lesion level with the adjacent skin and then saturating the remaining tissue by multiple injections of dexamethasone phosphate 2/ml acetate 8/ml suspension. Five such lesions were also treated with X-ray therapy. The amount of X-ray varied from 1000 to 2000 R. The results on the whole were no better than other lesions treated similarly but without X-ray therapy. Most but not all of the keloids treated on this patient have recurred, when only one saturation of the cut lesion with dexamethasone phosphate/acetate 2/8 suspension was carried out. From an etiologic viewpoint, it is interesting that an extensive abrasion of the right leg, following a motorcycle accident healed promptly. No keloid had developed 18 months later.

Summary

Keloids are notoriously resistant to treatment. The etiology remains obscure. Some of the more common and accepted methods such as the application of dry ice, X-ray therapy, various types of surgical procedures, and the injection of corticosteroid drugs into the keloids have been combined in a variety of manners. The results of treatment are being recorded photographically in a regular manner. Twenty-two keloids were treated thus, intensively, some over a three year period. The course of these keloids will be kept as treatment continues. The method of treatment has been modified gradually with the experience gained so far. Dry ice is probably the simplest procedure with hypertrophic scars such as follow some minor lacerations and some surgical procedures, but it has a limited value. X-ray has been helpful in one out of five of the keloids here treated. On the whole it is better to avoid it. Surgical results

Summary of Therapy of 22 Keloids

Name	Location	Dexamethasone Injections		X-Ray Therapy	Co_2	Skin Grafts	Results*
		Single	Multiple				
T. H.	Right Shoulder						
	A		x	x			Worse
	B	x		x			Unchanged
	C	x					Good
	D	x				x	Pending
	E †						Worse
	Left Front Shoulder						
	I	x					Worse
	II		x				Good
	Left Arm	x					Moderately Elevated
	Left Back Shoulder						
	1		x	x			Worse
	2	x					Worse
	3	x		x			Moderately Elevated
	4					x**	Moderately Elevated
	5	x					Moderately Elevated
	Sternum	x					Moderately Elevated
K. T.	Sternum		x (2)				Worse
D. H.	Ear Lobes	x (2)					Unchanged
G. J.	Arm		x			x	Excellent
L. C.	Knee		x		x		Unchanged
P. T.	Thigh		x		x		Slightly Elevated
J. O.	Chest		x				Unchanged

*Worse	Unchanged	Moderately Elevated	Slightly Elevated or Good	Excellent	Pending
7	5	5	3	1	1

† Right shoulder E hypertrophic scar after removal of sebaceous cyst
** Autograft plug

have varied so much that it is best to settle for cutting the keloid level with the adjacent skin surfaces. Multiple corticosteroid injections are helpful. These can follow surgery and can be repeated at 2 to 4 week intervals until the lesion remains level (hopefully); or if it should raise until it remains fixed at a constant size. When more extensive surgical procedures, such as complete excision with suturing of the wound, and when skin grafting procedures are tried, the corticosterioid injections should be delayed until primary healing has occurred. These methods have individual merit, and decided advantages when combined. Of the 22 keloids (Summary Chart) so treated, 7 were worse, 5 unchanged, 5 were moderately improved, 3 were good, one excellent, and one too recently treated to classify at present. Skin grafts have not been of great help. It would be wise not to treat sternal lesions. Recurrent lesions which have been intensively treated are best left alone. Patients with keloids of cosmetic importance should be given intensive care with the procedures described here. This combined method offers advantages over single procedures.

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Since we must investigate all hypotheses advanced by reputable investigators, we offer these reports by a Montclair neurologist and psychiatrist.

Possible Telesomatic Reactions

Berthold E. Schwarz, M.D./Montclair

The psychosomatic significance of various illnesses is well established. This paper explores the possible telepathic mediation of psychosomatic or "telesomatic" reactions.

Under controlled laboratory conditions, using sensitive mathematical methods, telepathic communications have been demonstrated by J. B. Rhine[10] in America, S. G. Soal[18] in England, and others. Although many of the early investigators of telepathy were psysicians, until the advent of psychoanalysis, psychiatry had relatively little to contribute to parapsychology. Since Freud there have been scattered psychodynamic studies[5]. Notwithstanding considerable conscious[7] and unconscious[8] resistance to this potentially revolutionary body of data, it is still a paradox that comparatively little investigation by psychiatrists has been undertaken. It has been suggested[12] that parapsychology would have more to offer psychiatry than *vice versa*.

In one of his earlier papers, Eisenbud[6] mentioned the likelihood "for a telepathic stimulus to occasion an asthmatic attack or any other set of physiological events." Although he asserted that he had "seen several examples of psychosomatic developments on a telepathic basis," he offered no examples. In a different detailed psychodynamic study[16], it was shown how a patient's incapacitating psychosomatic illnesses might have been induced (or at least strongly influenced) by a "sick" relationship with a telepathic mother. Examples in this same study and elsewhere[13] further show the tie-in of psychophysiologic factors and telepathy.

Despite Dean's laboratory experiments[2] and[3] Cadaret's intriguing review,[1] little has appeared concerning the practical, clinical aspects: possible telesomatic reactions. To date these essentially parapsychologic studies emphasize (a) the use of physiologic measures to define conditions under which ESP occurs, and (b) physiologic measures used as means of registering ESP responses. I reported[14 18] a series of 504 presumed parent-child telepathic espisodes showing many possible telesomatic and motor-acting-out responses. In these, it looked as if the parent's or the child's thoughts caused somatic motor (or autonomic) reactions in sender or receiver. The usual criteria for telepathy are uniqueness, simultaneity, actual or symbolic equivalence of thought and feeling, and telepathic tracer effects. Often it can be shown how the presumed telepathic episode will often recur in an almost predictable manner when the psychodynamic-situational constellations are similar. Psychiatric study technics are involved in unconscious mechanisms, manifold nuances of interpersonal relations, and various trancelike states of altered consciousness. Both psychiatric and laboratory physiologic investigations suggest that telepathy offers an attractive hypothesis for the understanding of psychosomatic diseases. The following cases present some possible telesomatic reactions.

Case One

"Last night, for the first time in years, I had a severe toothache. I told my wife about it at 7 a.m. and shortly afterward made an appointment with my dentist. At 10 a.m. my mother phoned to say she was having an extraction that day. Her last extraction was years ago. No one in my family knew about mother's trouble. When I saw my dentist later that day there was neither discernible disease nor reason for my complaint. I have had no recurrence since then. Could I

have picked up and somatized my mother's repressed anxiety over her trip to the dentist?"

Case Two

The 38-year old father of two children was awarded custody of them following his divorce nine years ago. Although the wife had left him on occasion in the past, she always returned and never threatened to take the children. During his psychiatric interview he said, "Even today, I don't understand it. At the time of our divorce things were at the worst. I was scheduled to work on Saturdays. One Saturday I left the house at 6:30 a.m. and got a third of the way to work when I suddenly became very ill. I had abdominal pain, and the cramps were so severe I couldn't drive. I rolled out of the car but when I turned around to go home the pain stopped. Because of this I decided to start for work again, but once again (for the second time) the pain returned. I then decided to go home. By the time I got to the house I had no pain, headache, or perspiration. It wasn't until the next evening that I discovered my wife's packed suitcases. I had no awareness of this at the time. She would not leave if I were around. I later learned that she had intended to take the children. I think it was because of this fact that I had the attack. She was most annoyed that I came home and was underfoot."

In this example the patient's security was threatened. He might have telepathically picked up this threat by his somatic reaction. Through being forced to return home he saved his children. The pains left twice, but only upon his decision to return home.

Case Three

A woman in her middle thirties with an old disability from poliomyelitis had been treated both in Holland and in the United States by the renowned Dutch healer,[9] Croiset the Clairvoyant.[20,21,22] Croiset asserted that he could influence muscular contractions: eversion, inversion, and dorsiflexion of the right foot. In a light trancelike state, he indicated the patient's appropriate muscular reaction by the direction of his outstretched hands. The patient's eyes were not on his hands. In fact, Croiset was in another room and it was impossible for the patient to see whether (and in what direction) he was "stimulating" her. Unfortunately it was also impossible for the observer to check precisely when and how Croiset was stimulating.

This American woman (who was in close rapport with Croiset) was seized with acute "fast heart rate, abdominal cramps, diarrhea" and malaise in Tarrytown, New York. She connected her autonomic reaction "to Croiset" but did not fully understand it until four days later. At that time, following an interview with the physician, she learned that at the approximate time of her reaction Croiset had unexpectedly landed (from a paragnostic Australian crime-sleuthing trip) at John F. Kennedy Airport in a state of collapse, with severe abdominal pain and malaise. Although he was expected to arrive in America several days later than his actual arrival, this was not definite and was never confirmed.

The woman's somatic reaction was not related to any similar illness for any member of her family or friends. It can be conjectured that the woman's abdominal reaction and half-awarness of Croiset. which coincided with his acute distress and unexpected proximity. might have been telepathically mediated — a way of telling her that the man upon whom she had pinned such high hopes for help was close by and in danger. And in turn, Croiset, alone in America and acutely ill, in his desperation, might have thought of his kind friend and patient with the old disability.

Case Four

A 10-year-old boy had a convulsion five years ago and nothing since. Because of this (plus an associated moderate, generalized dysrhythmia on the electroencephalogram) he had had yearly tracings and had been on anticonvulsant drugs in the interim. On the morning of his annual electroencephalogram, he had his second seizure. Contrary to their usual practice, the parents did not tell their son that they had planned to bring him from Atlantic City to Montclair for the electroencephalogram. It was wondered, therefore, if these kind parents could, by their uneasiness, have triggered their son's seizure through subliminal, unconscious means, or possibly telepathic psychophysiologic stimuli. There was nothing unusual in the patient's immediate history to account for this seizure.

Case Five

A thirteen-and-a-half-year-old girl with temporal lobe epilepsy was meticulously studied for eight and a half years and reported by my colleague, Dr. B. A. Ruggieri.[11] My contact with the patient was limited to performing serial electroencephalograms. These all showed marked generalized dysrhythmia and right temporal focal sharp-wave changes. Once a typical seizure occurred during the recording. Clinically the patient had hundreds of major and minor seizures and had been difficult to manage with drugs and psychotherapy. The latter was given for depressive reactions. During one of the sessions, telepathic and telesomatic exchanges occurred between the patient and Dr. Ruggieri. For example, Dr. Ruggieri experienced a "severe but momentary abdominal cramp. The thought went through my mind, 'I hope she does not get a spell,' since her convulsive disorder frequently manifested itself as abdominal epilepsy. I had experienced the cramp as my own but mentally associated to my patient's problems. Immediately thereafter this girl began to stare straight ahead and make swallowing movements. When it was over, she described her feelings: 'It felt as though my stomach was about to blow up.' Later when the daughter described this incident to the mother, the latter asked. 'Did you tell the Doctor you had this spell?' and the girl reportedly answered, 'I didn't have to. he sensed it'."

Dr. Ruggieri continued, "One day, while I was talking alone with this girl's mother, I was surprised when she spontaneously told me that on several occasions through the years while away from her daughter she had sensed that her daughter was having a convulsion and, on checking the matter as carefully as she could, she had found that her daughter had indeed experienced a convulsive episode at that same time. From my interviews with the daughter it was apparent that she had some emotional problems with her mother. Repeatedly in the past the mother refused to see a psychiatrist for the benefit of her daughter if not herself. However, the mother's history and my own experiences with the patient made me wonder about the possibility of either the mother telepathically detecting her daughter's seizures, or telesomatically causing them."

Case Six

A young Army wife was unexpectedly hospitalized for threatened abortion. Her mother (who was 56 years of age and hundreds of miles away) developed uterine bleeding at the same time. The older woman's last menstrual period had occurred eight years previously. She thought this was unusual because six months before this episode she had had bleeding when her second daughter, who lived more than one hundred miles away (and had no immediate contact with her) went into labor. The third episode of unexpected uterine bleeding occurred while the older woman was in New Jersey. At that time, her first daughter was in California. She had given birth to her baby seven weeks before the expected date. The older woman was not immediately aware of the relationships between her three bleeding experiences and her two daughters. She told her physician at the time because they seemed to be such strange coincidences. Twenty months after the last episode of bleeding, the older woman had a massive hemorrhage. Uterine carcinoma was diagnosed and she had a successful hysterectomy. Her episodes of pathologic uterine bleeding coincided with major obstetrical changes in the lives of her two daughters and might have unconsciously directed the older woman's attention to her illness.

The two grandchildren who were associated with the odd bleeding had congenital anomalies, and the earlier (the first born) grandchild also had anomalies. Possibly the grandmother had not developed her carcinoma at this time. Of the five grandchildren born during this period, the only one free of anomalies was also the only one *not* associated with the grandmother's bleeding. The last born was after the grandmother's hysterectomy (and of course, her incapacity to respond with bleeding) — if there was any relationship at all. Detailed genetic investigation of both daughters and their families failed to uncover any reason for these four tragedies.

This woman's husband, a very successful businessman, came from a "telepathic" family and at times had himself been aware of his involvement in various telepathic episodes.

Case Seven

During his psychotherapy, a 36-year-old businessman had many physician-patient "telepathic" episodes. He had a sadomasochistic relationship with his alcoholic, hostile, competitive, domineering father, who was also his boss. After years of abuse, and threats of being fired or quitting, the patient surprised everyone by leaving his father's employ and seeking work elsewhere. He took great precautions so that his father would not know where he sought work and block him. Some prospective employers were doubtful about hiring him because of their knowledge of the father's precarious health, family loyalties, and so forth. Finally he obtained a new job at a marked increase in salary. Only his wife and the prospective new employer knew his secret. The new job involved much soul searching since it was with a competitor of his father's in a different state, hundreds of miles away, and would mean major changes in his life — the final manifest separation from the unhealthy destructive dependency on his father. He later learned that at the approximate time of his agonizing decision, and while awaiting the call from the new employer, his father had a second coronary thrombosis. The first such attack was nine years before. This event, so fortuitously timed, shifted all the complex relationships and at the "zero hour" the patient had a change of heart and returned to his family company. However, this time he was put in full charge, as his father was now forced, on his physician's advice, to retire. It can be wondered if the tyrannical father had an (unconscious) telepathic awareness of his son's major decision and responded somatically when no other response might have sufficed.

Case Eight

While receiving psychotherapy for a depressive reaction, a 33-year-old physicist had many "telepathic" episodes with his physician. He also had some presumably telepathic dreams. A late afternoon dream vividly portrayed almost all the specific, detailed (censored) circumstances of his physician's anxiety over an unanticipated trip to a New York airport to see the acutely ill Croiset. The other dream apparently detected in surprising detail his physician's daughter's surprise birthday gift of an old-fashioned fourposter bed and canopy. A third episode was the physician's waking from a sound sleep in the early hours of the morning by the physicist patient's telling him telepathically, "I'm alright now — had abscessed tooth-extracted." Earlier that day the patient telephoned the physician because of a toothache. His own dentist had previously examined him and told him there was nothing wrong with the tooth: the same advice he had received from a Midwestern dentist four months ago when he had a similar toothache. The physician advised his patient to see another dentist, and no further thought was given this until the veridical nocturnal episode.

In his sessions the physicist was aware of some of the face-to-face patient-physician telepathy and contrary to the usual custom, these communications were explored in treatment. Because of his interest in telepathy, one day the physicist participated as a subject, in one of Dean's well-controlled laboratory tests for telepathy.[4] The presumed episodes were monitored with the plethysmograph. On two separate occasions the physicist got attractive responses: pronounced transient tachycardia and change in vasoconstrictive states when a specific sender looked at a card saying (or symbolizing) "mother." It was hoped that with additional experiments a statistically significant result might be obtained. The patient had some deep-rooted problems with his mother. The telepathic response did not happen with other names.

During one of the experiments the successful sender was disturbed over some unanticipated extraneous sounds on his earphones. The patient, who was in a different part of the building and had neither earphones nor other connections with the sender, responded to this unpleasant intrusion in the same telepathic-physiologic way: "the biggest reaction . . . ever seen. It leads us to try better." With a different "cold, sourpuss sender" there was no evidence for telepathy.

In therapy the patient became aware of the superficial similarities between the successful sender and his mother. Both had a gushy, smiling effusiveness. Following the second successful telepathic-physiologic tests the physicist became depressed. He did not know why until therapy, when he recognized that he repressed his rage toward the successful sender who risked his life, on the trip back from the laboratory. The sender, in the physicist's opinion, was a reckless automobile driver. This dissociation of the sender's reckless driving was similar to the physicist's pattern of repressing all anger toward his mother's analogous behaviour.

This interesting laboratory and clinical datum justifies the speculation that with the passage of time various

psychosomatic states could develop or be precipitated where there is an unhealthy parent-child telepathic rapport. That might apply, for example, to possible paroxysmal tachycardia, hypertension, hyperthyroidism, acute peptic ulcer, ulcerative colitis, and so forth. As indicated in the example of the physicist, all commonly recognized communications and those that occur on an unconscious, nonverbal basis could, *via* telepathic mediation, be vastly complicated by somatic shortcircuiting.

From these examples, it would appear that telesomatic reactions are part of a continuum of interhuman relatedness—physiologic expressions of telepathically sent thoughts, behavior, and affect. The process can be partial for any one of these areas or (as in these examples) complex. The telesomatic reaction occurs on an unconscious level and is almost totally out of the participants' awareness. Unless the data were carefully collected and scrutinized with a telepathic hypothesis in mind, the event could be entirely missed. Identification of telesomatic reactions is facilitated by the tracer effects which appropriately tag the events. Since the telesomatic reaction happened out of awareness clinically and also in one cited well-controlled laboratory test, it can be supposed that it might occur much more often than is commonly thought. Hence, it is worthy of serious consideration from both the practicing clinician and the researcher.

Summary and Conclusion

The hypothesis for telepathic mediation of psychosomatic (telesomatic) reactions is illustrated by eight case reports. This interesting area of investigation is thought to have much potential and theoretical value for the understanding of the causes and treatment of psychosomatic illnesses, pain reactions, and so forth.

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This is the first of two papers on the subject of alcoholism at the Academy symposium. The second paper, dealing with chronic alcoholism, will appear in next month's issue of this JOURNAL.

Acute Care Of The Alcoholic*

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Many physicians are graduated from medical schools totally unprepared to deal with the alcoholic patient. A student may be exposed to many lectures on the auto-immune diseases, but he will probably treat very few in his practice. On the other hand, his preparation in the field of alcoholism is often limited to one or two hours of instruction, yet a large number of his patients will be alcoholic. If he trains in an urban general hospital, anywhere from 20 to 60 per cent of his adult patients may be alcoholic; later, in private practice, the number will also be large. In our present society where alcohol is freely available and widely used, *one out of every twenty drinking adults is or will become alcoholic.*

Learning to recognize the alcoholic patient is not easy since he rarely volunteers the truth about his drinking. The untrained physician, like the layman, tends to think of the alcoholic as the Bowery bum, the "visible 3 per cent." Alcoholism is often over-diagnosed in the accident room and in the clinic, while it is under-diagnosed in the private room or office. The clean-cut, well-mannered, well-dressed patient can be as severe an alcoholic as the skid-row derelict, and just as much in need of help.

Acute alcoholism presents less of a diagnostic problem in the Emergency Room when the patient is rambling and confused, if not actually comatose. He may diffuse the odor of liquor from his breath and clothing. When alcohol is merely incidental to some other problem, the detailed history becomes crucial. The patient, however, is hardly in mental condition appropriate for interview, and little additional information may be obtained when he is brought in unattended by spouse or friend.

In uncomplicated acute alcoholism, we are dealing primarily with the effects of a depressant drug. Alcohol is absorbed quickly from the gastrointestinal tract, provided this has not been delayed by a large meal. Once absorbed, alcohol is broken down in three principal organs: the heart, liver, and kidneys. The role of the liver and kidney in the catabolism of alcohol has long been known. It was only recently that the active role of the heart in the metabolism of alcohol was recognized. This knowledge developed retrospectively from the frequent observation of the deleterious effort of alcohol on the heart muscle as reflected in the often serious impairment of its function.

The enzymatic reactions concerned in the catabolism of alcohol are centered chiefly about alcohol dehydrogenase, through which alcohol is converted into acetaldehyde at a rate governed by the activity of this enzyme. Although it may be possible to interfere with its function, little is known about what can accelerate the activity of this enzyme by means of drugs. Insulin has been used but has not proved to be effective. Caffeine and other

* Adapted from a symposium on alcoholism, sponsored by the Academy of Medicine of New Jersey and the State Department of Health. This paper was delivered on February 14, 1967 at the Middlesex General Hospital in New Brunswick, New Jersey.

stimulants may convert a sleepy drunk to an active one; but the patient is no less drunk. In most instances, the imbiber's intake of alcohol is self-regulated by the fact that when his limit of tolerance is reached he "passes out" and is protected thereby against additional intake. As a result, acute alcohol poisoning is rarely fatal. The exceptions are seen occasionally in the young college boy who drinks an entire bottle in a short time on a "dare" so that before he is compelled to stop he has taken in a lethal dose.

Treatment is largely a matter of waiting out the effects of alcohol, and does not differ materially from the treatment of barbiturate overdose. Attention must be given to maintaining an airway. If vomiting occurs, the patient should be watched carefully so that he will not aspirate into the lungs with resulting pneumonia, abscess, or asphyxia. Alcoholics often mix alcohol with barbiturates or tranquilizers. The physician, therefore, should consider the possibility of a mixed intoxication. If even the remote possibility of wood alcohol poisoning exists, the patient requires energetic treatment to avoid its dangerous complications involving the eyes and other organs. The accepted treatment at present is administration of ethyl alcohol (ethanol), which acts as a specific metabolic competitor against methanol, blocking its breakdown into toxic by-products while permitting its gradual elimination. This may take days. Careful and constant supervision is necessary.

Alcohol-induced hypoglycemia is an important, and potentially dangerous complication. When this type of hypoglycemia was first described, the investigators assumed that it occurred chiefly in subjects who had been fasting or semi-starved before and during an acute flare-up of chronic alcoholism. Experienced practitioners now recognize that alcohol-induced hypoglycemia can occur even when nutrition has been good. It has occurred in children. It can ensue when blood alcohol levels are fairly low, i.e. below levels usually associated with frank drunkenness. One should suspect the hypoglycemic state when the alcoholic is brought in depressed and unconscious or partly conscious, rather than boisterous and cheerful. A sample of blood should be drawn at once for blood sugar determination. Before the report is back, the patient should receive glucose intravenously.

In some instances the problem is complicated by previous treatment with Antabuse® (disulfiram). This drug blocks the enzymatic breakdown of acetaldehyde as the latter forms during the catabolism of alcohol. Anyone drinking after the ingestion of Antabuse® may experience flushing, palpitations, dyspnea, nausea, vomiting, and hypotension. Years ago, when the drug was new, the dose was often in huge amounts, up to three Grams per day. Sometimes the reaction was so severe as to cause death. Also, at this high dosage transient psychotic reactions occurred. At dosage levels now used, 250 to 500 milligrams a day, there have been no deaths or psychoses reported but the disulfiram-alcohol reaction is still frightening for the patient and sometimes also for the unwary doctor. Vitamin C and an antihistamine such as Benadryl will control the reaction.

One of the prime responsibilities of the physician is to examine the acute alcoholic meticulously for evidences of trauma. The patient frequently "feels no pain" and may give no hint that he has sustained a fracture or serious blow on the head or elsewhere. Evidences of both old and fresh bruises over bony prominences may indicate the frequency with which the patient has fallen during his alcoholic bout. These may be important indirect evidences of head injury. If any hint exists of a space-occupying intracranial lesion, the patient should be examined carefully for the possibility of subdural hematoma. In some instances, this may have been present for weeks or months and may have undergone secondary encapsulation. When the sac develops a semipermeable membrane it may swell progressively and cause serious pressure effects as fluid accumulates. One such effect is the development of convulsive seizures.

Either intake or withdrawal of alcohol may precipitate seizures in an alcoholic. Seizures

may reflect pre-existing convulsive disorder. In these cases, one or two drinks may precipitate a seizure. When he is brought into the Emergency Room in the postictal state, the physician may erroneously attribute his stupor to alcohol alone.

The "withdrawal stage" of acute alcoholism deserves as much attention as the acute depressed stage. What a normal person experiences in the form of "jumpiness" and "jangled nerves" four or five hours after a cocktail party is multiplied many times in the alcoholic who is on the rebound from three or four days or that many months of continused alcohol intake. During the first 24 hours after his supply of liquor is abruptly cut off, he become jittery and sleeps restlessly. By the end of 48 hours he is often agitated, tremulous, and in a state of hypermetabolism, sometimes manifested by a temperature reaching 102, by sweating, and by tachycardia. During this period he may also have seizures. By the end of three to five days the patient may be in a state of acute auditory, visual, or tactile hallucinosis.

The treatment of the stage of hallucinosis ("delirium tremens") consists essentially in careful nursing and doctoring. The death rate ranges between two and fifteen per cent depending upon the quality of such treatment. Death is sometimes ascribed quite simply to "cerebral exhaustion" because of certain resemblances to the picture of heat stroke, especially when fatal hyperpyrexia develops. Such termination is now rare. In some fatal cases, there are widespread fat emboli in the brain and lung. Seizures with accompanying asphyxia, aspiration, or both, have also been implicated.

In some instances the patient may appear to be doing quite well when suddenly, sometimes early, sometimes late in his hospital course, he collapses and dies. Why this should happen has never been entirely clear. Some indirect evidence points to acute cardiac arrhythmia, possibly resulting from myocardial injury or from electrolyte imbalance.

Management of seizures is extremely important. Diphenyl hydantoin is generally used as an anticonvulsant but may be inadequate in some cases. Perhaps the chief reason for the failure of Dilantin® is the latent period required before its effect becomes established, especially in the usual dose of 100 milligrams on admission and 100 milligrams three times a day. The correct initial dose of diphenyl hydantoin should be much larger, perhaps a full Gram, intramuscularly over 24 hours. Fifty per cent magnesium sulfate solution given in doses of two cubic centimeters intramuscularly three times a day for three days may be highly satisfactory. In rare instances, this amount may prove excessive, as shown by fall in blood pressure and drowsiness. A second advantage of magnesium sulfate is that it also relieves the magnesium deficiency syndrome which is a common finding in alcoholism, believed by some to account for the patient's tremors and agitation. Through electroencephalography, Victor[1] tested the effect of magnesium on the seizure threshold in alcoholics. A stroboscopic light, flashed into the eyes of the subjects, served as the epileptogenic stimulus. Results showed that the seizure threshold correlated well with the level of magnesium ion in the serum. After the level rose, in response to parenteral magnesium sulfate, the seizure threshold rose in corresponding degree.

The agitation and hallucinosis of the withdrawal phase respond well to Librium® provided the physician gives adequate doses. An interesting paradox of chlordiazepoxide therapy is the greater effectiveness of the oral than the parenteral form of Librium©. Twenty-five milligrams given orally have an effect equivalent to 75 or 100 milligrams intramuscularly. To get best results, give 100 milligrams of chlordiazepoxide (Librium®) on admission and repeat this every hour until the desired effect is achieved.

An old standby is paraldehyde given both as an anticonvulsant and as a sedative. Despite its unpleasant smell, paraldehyde has been favored by many physicians in treating the acute alcoholic. It is safe, especially if given

orally. Some patients even prefer it to other drugs. Indeed, addiction to paraldehyde has been observed. Intramuscular injection is undesirable, especially in the doses required (10 to 15 cubic centimeters), because of the intense local irritation.

Other physicians prefer Sparine.® This is a brand of promazine which, while effective, has occasionally led to unpleasant results. In some cases a fall of blood pressure occurs which is of such severity that the nurse may declare the patient to have suffered "cardiac arrest" because of her inability to detect the pulse or blood pressure. Usually elevation of the legs will restore the blood pressure; but this sort of reaction can be unnerving. This experience with Sparine® and certain other drugs lends force to the axiom that a physician should never use a drug with which he is not completely familiar, especially when the patient's condition is already precarious.

Many alcoholics become markedly dehydrated and potassium depleted. Replace fluids and electrolytes promptly. Over-hydration (especially with electrolyte-poor solution) may provoke serious electrolyte imbalance. Always evaluate renal and cardiac status before fluid replacement, as with any patient. If five per cent dextrose and water are given in a nutritionally depleted patient, thiamine should also be provided to avoid Wenicke's encephalopathy. This need is due to the fact that vitamin B is required for the utilization of carbohydrate by the tissues. In a subject largely depleted of vitamin B_1, the addition of carbohydrate in any form may deplete vitamin B_1 reserves to the point of complete exhaustion. Give large doses of vitamin B complex simultaneously to aid in the metabolism of the added carbohydrate.

Alcohol has a direct toxic effect on the cells of the bone marrow, as reflected in the development of intracellular vacuoles much like those which appear with phenylalanine deprivation or during chloramphenicol therapy. The megaloblastic anemia which may then appear may well be due to the suppressive effect of alcohol on folic acid metabolism. Other deficiencies include riboflavin and niacin deficiency, all of which must be properly treated by use of the entire vitamin B complex rather than its individual factors alone. Vitamin C deficiency is also common.

Comparing acute alcoholic withdrawal in the hospital with management of such a patient outside the hospital, i.e., home, the latter is more difficult. Adequate supervision and follow-up are often harder to achieve than in the hospital. If the physician has prescribed a sedative medication, there is a strong likelihood that the patient will take the entire amount at once instead of in divided doses. For this reason, you should never permit him to have more than what would amount to a safe dose if he swallowed all the tablets at once, and combined them also with alcohol.

In subsequent follow-up, the physician should require the patient to visit his doctor at least daily if not twice a day as long as necessary.

A number of disorders associated with acute alcoholism require separate treatment beyond the scope of this discussion. Among these are the alcoholic fatty liver, cirrhosis, acute pancreatitis, alcoholic encephalopathy, alcoholic gastritis, alcoholic myocardiopathy, and peripheral neuropathy, any or all of which can complicate the treatment of the alcohol withdrawal state, thereby adding to the complexity and also to the challenge of working with this patient group.

130 West 16th Street

Proposed here is a way that may make abdominoperineal resections unnecessary in handling certain neoplasms of the large intestine.

Posterior Proctotomy*

Peter J. Guthorn, M.D. and Carl Guzzo, M.D./Neptune

The purpose of this report is to focus attention on a valuable, but relatively uncommon surgical procedure.

The proper management of rectal tumors requires accurate pathologic diagnosis. This can be accomplished with certainty only after complete removal and microscopic examination at many levels. The villous adenoma particularly requires meticulous and multiple examination as some areas of malignant change are usually present.

Posterior proctotomy may make abdominoperineal resection unnecessary in the treatment of large, benign tumors, or localized low grade malignant tumors, which cannot be removed endoscopically; also for tumors which cannot be delivered through the anal opening by traction and eversion. The posterior approach was pioneered by Dr. Paul Kraske in 1885. It was later popularized by others. We favor the technic described by Crowley and Davis in 1951. We have added one modification: oblique prolongation of the mid-line incision from the extremities of the longitudinal incision. This affords extra exposure, particularly in the obese, elderly patient.

A typical illustrative case was that of a 70-year-old woman previously treated for diverticulosis in the colon and for symptomatic hemorrhoids. New presenting complaints were rectal bleeding, recurrent abdominal cramps, multiple small bowel movements and a sense of fullness in the rectum. A five-centimeter villous appearing rectal tumor was discovered on the right, lateral, rectal wall eight centimeters above the dentate line. Multiple endoscopic biopsies demonstrated a villous adenoma. The bowel was prepared with saline purgative, enemas, and a clear fluid diet to attain mechanical cleansing rather than antibiotic sterilization of bowel contents. The surgical procedure was carried out under caudal anesthesia with the patient in the flexed, prone position. A midline sacrococcygeal incision was extended obliquely to the right from the lower end of the incision for five centimeters and to the left from the cephilad end for eight centimeters. The coccyx was exposed, freed and removed. The poorly developed levator ani muscles were divided longitudinally. The rectal walls were freed by digital dissection. An incision was made through the full thickness of the rectum, localization being guided by a finger inserted through the anus. The edges of the rectum were grasped, everted, and the entire polyp, its base and a narrow margin of normal mucosa excised. A careful search was made under direct vision for additional polypi. The rectal wall was closed with a double layer of closely spaced interrupted chromic catgut mattress sutures. Two suction catheters were placed in the wound out of direct contact with the rectal closure. These were sutured to the skin edge and the wound closed after saline lavage of the operative area. Both tubes were attached to low pressure suction. The tubes were irrigated with saline intermittently until drainage had ceased, in this case on the fifth day. Bowel activity was discouraged by feeding the patient clear fluids for the first four days. Digital examination was deferred until the eighth day. Examination of the pathological specimen demonstrated complete removal with an adequate normal margin of bowel. The patient left the hospital on the ninth day with her wound completely closed. A normal bowel habit was attained by the fourteenth day.

In summary, this simple surgical procedure fills an important gap, and should be part of the armamentarium of all surgeons treating neoplasms of the large intestine.

* From the Jersey Shore Medical Center, Fitkin Hospital, Neptune.

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Two patients taking an anabolic agent were given routine anticoagulant therapy with sodium warfarin. Prothrombin times rose to higher values, and were maintained for longer periods of time, in spite of vitamin K_1 administration. This potentiating effect on anticoagulant therapy must be recognized. Anticoagulants should be used in smaller dosage when given concomitantly with this anabolic agent.

Potential Dangers In The Combined Use Of Methandrostenolone And Sodium Warfarin

Frank C. Dresdale, M.D./Plainfield and James C. Hayes, M.D./Augusta, Maine

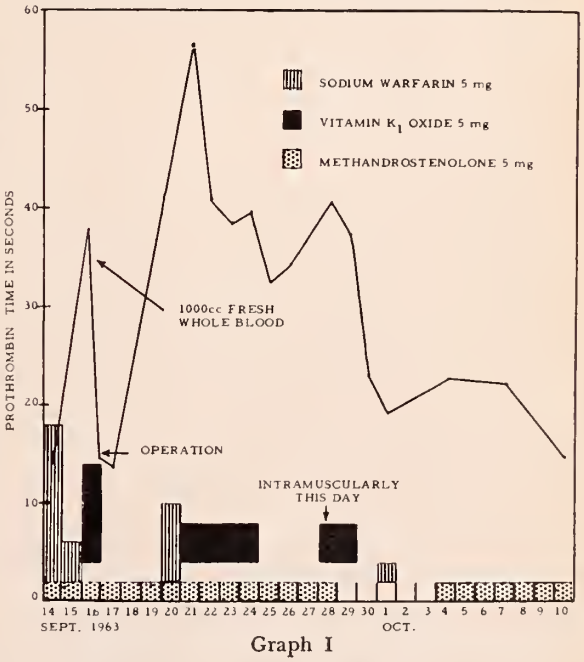
Anabolic agents and anticoagulants are frequently used concurrently. It is our purpose to alert the physician to the possibility of an exaggerated response to the anticoagulant in some of these cases.

An 80-year-old woman, with a past history of two strokes and a residual right hemiparesis, sustained an intertrochanteric fracture of the left femur. This had been repaired with a Smith-Peterson nail and a bar fixation, with a good result and the patient was discharged. Her only medication, on discharge, was methandrostenolone (Dianabol®), 5 milligrams daily. She was readmitted to the Muhlenberg Hospital eight days later, with thrombophlebitis of the left femoral iliac venous system. Two days prior to admission, with a normal prothrombin time, she had been given sodium warfarin (Coumadin®), 40 milligrams. A dose of 10 milligrams was given the next day.

On admission, the blood count revealed RBC 2,290,000, hemoglobin 7.8, and hematocrit 24 per cent. Lee-White coagulation time was 9 minutes 55 seconds (normal) and the prothrombin time 37.8 seconds (control 14 seconds). She was given a liter of fresh whole blood and vitamin K_1 oxide (Konakion®), 25 milligrams, which brought the hemoglobin to 13.2, the hematocrit to 37 and prothrombin time to 14.4 seconds. The same day, thrombectomy and ligation of the left common femoral vein with periarterial sympathectomy were done. The patient continued to receive methandrostenolone, 5 milligrams daily. The next day the hemoglobin was unchanged the hematocrit was up to 41 per cent, and prothrombin time down to 13.8 seconds.

On the fourth postoperative day, anticoagulation was resumed with sodium warfarin, 20 milligrams. On the following day the prothrombin time was 56.8 and vitamin K was begun. This was given in a dose of 10 milligrams daily for four days. The prothrombin time fell to 32.6 but on the 12th postoperative day was up to 41 seconds.

Because of the possibility that the anabolic agent was having an adverse effect on the prothrombin time, it was discontinued. Vitamin K was given, 10 milligrams intramuscularly, on the twelfth postoperative day and 10 milligrams orally two days later. By the 14th postoperative day, the prothrombin time had fallen to 19.4 seconds and sodium warfarin, 5 milligrams, was given that day. Without further anticoagulant, the prothrombin time remained in the therapeutic range until discharge on the 24th day. (See Graph I)



Graph I

* Formerly at Muhlenberg Hospital, Dr. Hayes is now associated with the Augusta General Hospital, Augusta, Maine.

A month after discharge, hemoglobin was 13.7, hematocrit 40 per cent, alkaline phosphatase 17.3 (normal 4-10 Bod. u), BSP 11.5 per cent retention, prothrombin time 13.5 seconds (control 14 seconds). In view of the altered liver function studies, methandrostenolone was discontinued.

Seven months later and after clinical recovery the following clinical experiment was performed:

On May 20, 1964 with B.S.P. showing 3.5 per cent retention (normal), patient was placed on methandrostenolone, 5 milligrams daily. Nineteen days later B.S.P. showed 7.3 per cent retention, prothrombin time was 13.2 seconds (control 14 seconds). Partial thromboplastin time was well within normal limits with both platelin and Thrombofax.® In spite of some B.S.P. retention, the coagulation process remained normal.

She was then given sodium warfarin, 10 milligrams daily, for 4 days beginning June 10, 1964. The prothrombin time was 12.8 on June 11th; 16.8 on June 12th; 20.3 on June 15th; 18.8 on June 17th; 16.8 on June 19th and 12.3 seconds on June 23rd. Mathandrostenolone was discontinued this day. Thus the effect of the sodium warfarin lasted for 10 days.

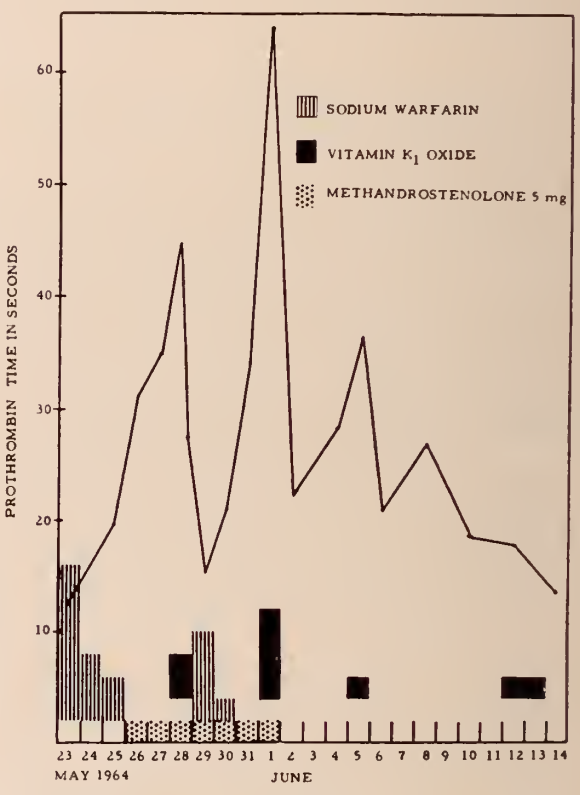
Ordinarily sodium warfarin is considered to be a fairly predictable anticoagulant.[1] However, ideal control of anticoagulation is not easily achieved by agents now in common use. Many factors may act to cause an increased or decreased prothrombin time response. In this instance (increased prothrombin time response), factors were sought in diet, other drugs, medical conditions present, and possibility of laboratory errors, without success. It was then assumed that the anabolic agent was the contributing factor.

During this time another case came to our attention:

A 66-year-old woman was admitted to the Muhlenberg Hospital, with a history of lower back pain dating back to a fall six months earlier. There had been some relief with symptomatic treatment but she fell again aggravating her condition. She had had several hospital admissions for episodes of coronary artery disease as well as an episode of thrombophlebitis. Work-up and orthopedic consultation led to a diagnosis of degenerative lumbar disc disease with osteoporosis. Laboratory studies were normal including all blood counts, urinalysis, FBS, BUN, cholesterol, cholesterol esters, uric acid, alkaline phosphatase, calcium, phosphorus, cephalin flocculation. SGPT, SGOT, serum lipids, PBI, serology, electrophoretic pattern, and bromsulfalein tests on several occasions.

Routine orthopedic treatment was recommended including traction and anabolic therapy. Because of the past history of thrombophlebitis, and the limited activity (as the patient was in traction) it was decided to start anticoagulant therapy with sodium warfarin. In view of our previous experience with methandrostenolone and sodium warfarin and their combined effect on the prothrombin time, the program was handled expectantly.

On May 23, 1964, with prothrombin time 12.3 seconds (control 14 seconds) sodium warfarin was begun with 40 milligrams being given that day, 20 milligrams on May 24th, and 15 milligrams on May 25th. On May 26th the prothrombin time was 31.3 seconds and methandrostenolone, 5 milligrams daily, was begun. Two days later, without further sodium warfarin, prothrombin time had risen to 44.8 seconds and vitamin K was given. Graph II indicates the effect of the three drugs on the prothrombin time over the next two weeks.



Graph II

The effect of sodium warfarin on prothrombin time can be seen for four or five days. Other than hemorrhage, the toxic and side effects of sodium warfarin are very rare.[2] Vitamin K readily returns the prothrombin time to normal, although (due to cumulative effects of warfarin) the prothrombin time may again lengthen for the succeeding three or four days.

During each of the three courses of methandrostenolone therapy cited above, a heightened and prolonged response to sodium warfarin was observed. In the first case [because the patient was severely ill with thrombotic disease and under stress] the heightened response to sodium warfarin was initially at-

tributed to her clinical status. Only after multiple doses of vitamin K failed to elicit the expected correction of prothrombin time did suspicion arise that methandrostenolone was possibly playing a part. After the anabolic agent was stopped, the prothrombin time began to respond to vitamin K in the usual way.

The increased response to sodium warfarin in patients receiving anabolic agents has been observed by Pyorala and Kekki.[3] Their observations are in agreement with our experiences.

Vitamin K will correct an increased prothrombin time in the 30 to 40 second range within 48 hours, in doses of 10 to 20 milligrams in an uncomplicated case. The patients on methandrostenolone required more vitamin K and had less response. In one case 55 milligrams were given with only partial response.

In one instance (case I) 50 milligrams of sodium warfarin had produced a prothrombin time of 37.8 seconds which was corrected by 25 milligrams of vitamin K and a transfusion of 1000 cc. Five days later a 20 milligrams dose of sodium warfarin resulted in a prothrombin time of 56.8 sceonds despite 10 milligrams of vitamin K given during the rise. Thus, despite the fact that the patient had a normal prothrombin time in the interim, some effect of the combination of methandrostenolone and sodium warfarin remained so that, when more sodium warfarin was added, 20 milligrams evoked more effect than 50 milligrams had originally. The mcehanism of this effect remains obscure. Although B.S.P. was slightly altered in one patient, it was not affected in the other and it is probable that the effect we observed is not directly related to changes in B.S.P.

Methandrostenolone is one of the C17-alkyl substituted derivatives of testosterone. It is a relatively weak androgen but used for its distinct anabolic effect. Alteration of hepatic function has been seen primarily after the use of the oral steroids when the substitution of a methyl or ethyl group at C17 has resulted in increased oral efficacy of the steriods but also has enhanced their hepatotoxic effect. Clinically significant hepatic damage is rare[4] when C17-alkylated anabolic steroids are given in the usual therapeutic dosage, but minor and transient increases in bromsulfalin retention and serum transaminase have been noted,[5] as well as a potentiation of the effect of coumarin and indanedione anticoagulants on the blood clotting factors.[6]

Pyorala, Myllyla, and Kekki[4] found it reasonable to assume that this decreased anticoagulant tolerance was not due to a retardation of the metabolism of the anticoagulant drugs and suggested the possibility that the anabolic agents affect the metabolism of vitamin K and diminish the stores of this vitamin available for the counteraction of the effect of the anticoagulants.

Thus, while the observed effect on the prothrombin time is real (and the mechanism of this action is not known), both anticoagulants and anabolic agents may often be indicated in the same patient,[7] as in the authors' cases. In addition, Gudbjarnason *et al.*,[8] in work on induced or simulated coronary occulsion in dogs, have demonstrated benefits in healing from the administration of anabolic steroids. This work, still underway, has not been tried in humans, but could conceivably lead to more general use of anabolics in conorary occlusion, where anticoagulants have been frequently employed. The possible use of anticoagulants in the care of vascular problems in large numbers of our aging population, where anabolic agents might also be used, makes the findings described more vital.

Conclusion

The potention danger to patients receiving both methandrostenolone and sodium warfarin is evident and physicians should be aware of the possibility of untoward effects in using these agents in combination.

The authors are indebted to the Department of Medical Communications, CIBA Pharmaceutical Company, Summit, New Jersey, for aid in the preparation of the graphs and manuscript.

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1107 Thornton Avenue

The Predictability Of Suicide

Western man has usually regarded suicide as the most irrational and unpredictable of all individual actions. Yet, according to Dr. Mathew Ross* the approaching attempt is so predictable that many suicides could be prevented by appropriate intervention.

Practical diagnostic clues to impending suicide are available to the physician. Dr. Ross insisted that "every physician can do more than he is now doing to reduce the shocking rate of suicide." About 25,000 persons are known to commit suicide in the U.S. every year, making suicide the ninth most frequent cause of death. The number of reported suicides would be much greater if the cause of death was not so frequently obscured because of social, economic, or legal considerations.

The most general indication of impending suicide is emotional illness manifested by some significant change in basic biologic functions and behavior that cannot be explained by physical examination. Many who committed suicide had been seeking medical help for a variety of minor physical illnesses. These visits to a physician, as well as the suicide attempt itself, may be viewed as a cry for help.

In three out of four cases, Dr. Ross said, the emotional ills that precede suicide are depression or alcoholism. He cited among the symptoms by which depression is frequently recognized; fatigue, loss of the sense of well-being; changes in sleep pattern, especially early-morning awakening with a feeling of fatigue; loss of appetite, particularly in the morning; weight loss (or weight gain from the use of food as a tranquilizer); behavior changes, including significant changes in work, recreation, and social patterns; alcoholism; sexual promiscuity; dizziness, headaches, blurred vision, dryness of the mouth, shortness of breath, and urinary frequency.

A typically American suicide risk is a man, unmarried, separated, or divorced, aged 45 years or more, who in the spring or autumn complains of recently impaired physical health. Questioning by an astute physician, said Dr. Ross, may reveal:

A previous carefully planned, recent, serious suicide attempt employing a violent method.

A history of suicide attempts in the patient's family.

Evidence of real, threatened, or fantasied loss, such as loss of health, a loved one, self-esteem, financial well-being, or even loss of appearance.

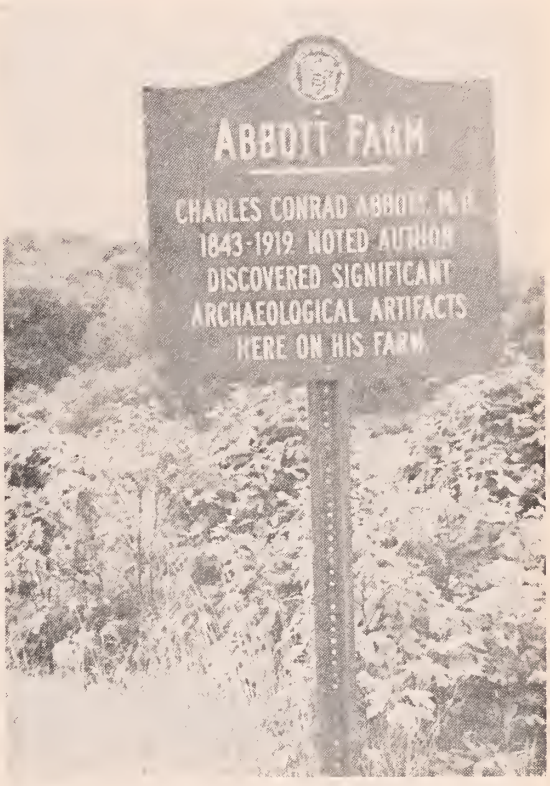
* Dr. Ross of Harvard Medical School gave this report on June 20, 1967 to the AMA scientific session in Atlantic City.

One of our State's distinguished truants from medical practice was Charles Conrad Abbott, M.D., who was an authority on the Lenni Lenape Indians and a major contributor to archeology in our State.

Charles Conrad Abbott, M.D. (1843-1919)*

Lucy Aiello, M.T./Trenton

New Jersey physicians can take quiet pride in the honor accorded a unique figure of nineteenth century science, Trenton's Charles Conrad Abbott, M.D., (1843-1919). The State recently issued a roadside marker designating the Abbott Farm in Hamilton Township (Mercer County, New Jersey) as an official historic site. This tribute recalls the provocative discoveries of primitive stone implements Dr. Abbott made on his Delaware River bluff farm. Dr. Abbott's work focused world-wide interest on post-Civil War Trenton as the possible locus of a Stone Age Man in New Jersey.



As early as 1867 Dr. Abbott began extracting crude, chipped stone implements from the glacial-age gravel beds of the Delaware River, just below the bluff of the Abbott homestead farm, *Three Beeches.*[1] The obviously rough workmanship (and the fact that the implements were discovered in strata far below that in which ordinary Indian relics were observed) convinced Dr. Abbott that his discoveries were the product of a society less sophisticated and more primitive than the historic Lenni Lenape Indians. Further investigation revealed an impressive similarity with stone implements attributed to the European Stone Age peoples.

In 1876 Dr. Abbott's Book, *Stone Age In New Jersey* created a sensation because of the author's daring announcement that he had discovered positive proof that man in the Delaware Valley harked back to the end of New Jersey's Ice Age, when the melting glacier and moderating temperatures brought primitive hunters in the valley in search of game.[2] This issue became an international scientific *cause célèbre.* Conservatives argued that the stone implements were merely rejects of Indian tool-makers' stone quarrys that had been washed down from the upper Delaware River in Pennsylvania. The skeptics would not believe that this was evidence of a Stone Age culture in New Jersey.[3]

* This project is supported by a grant from the American Philosophical Society. Miss Aiello is a medical technician at the Cardiovascular Laboratory of the St. Francis Hospital in Trenton.

Undaunted by the rebuff, Dr. Abbott continued with his excavations of the Delaware Valley. For over forty years he dug his way through acres of dirt, stone, and gravel. He painstakingly excavated every locally known Indian site. These heroic efforts strengthened his own convictions of a Stone Age in New Jersey. Dr. Abbott, however, failed to convince Victorian scientists of a great antiquity for man in New Jersey. Ultimately he did win an academic victory. His archaeologic investigations stimulated the scientific testing of theories that actually led to the foundations of archaeology as an important American science. Later investigators[4] up-dated Abbott's "Stone Age" to the Paleo-Indians who first arrived in the area six to ten thousand years ago.

Dr. Abbott's pioneer work in New Jersey archaeology was one facet of a brilliant tripartite career in science. Charles Conrad Abbott was born in Trenton, New Jersey in 1843. He was the son of prominent Delaware Valley Quakers whose ancestors were among New Jersey's earliest settlers. He was an egregious blend of blustering Yorkshire traits, combined with an innate scientific disposition, inherited in large part from the maternal side of his family, the Conrads of Philadelphia, who had distinguished themselves in botany, geology, and mineralogy. He received his M.D. degree at the University of Pennsylvania in 1865. His medical training served as the cornerstone of his triple careers: natural science, Indian ethnology, and archaeology.

An overriding preference for natural science dissuaded the young physician from private medical practice. Subsequently, Dr. Abbott and his family moved to the homestead farm, *Three Beeches*. The farm was in Hamilton Township, just outside Trenton, on the southeasterly bluff of the Delaware River two miles below the falls. The irregular topography of the land, the swampy meadows and wooded hillside included in the tract, made the farm an attractive shelter for an unusual variety of wildlife. Dr. Abbott's perceptive observations of their habits, and his detailed cataloging of the natural life of the entire Delaware Valley represented the first objective natural science survey of the area in nearly a century. He contributed articles on this to leading scientific periodicals of the era. He also adopted the locale as the background for several popular "nature" books.

In pre-colonial days *Three Beeches* had been the site of a large Lenni Lenape Indian village. Relics of their occupation were found inches below the surface soil. Dr. Abbott's interest in Indian ethnology stemmed from the vast collection of artifacts he had exhumed from his farmland and the surrounding areas. His competence in Indian ethnology was aptly demonstrated when he was appointed[5] to identify the Indian artifacts brought back by the 1879 United States Geologic Survey west of the one-hundredth meridian.

During his lifetime Dr. Abbott achieved a distinction enjoyed by few men. He was appointed to several major scientific positions. At the age of 22 he was appointed[6] a member of the New Jersey Geological Survey of 1865. A few years later he became associated with Harvard University's Peabody Museum of American Archaeology and Ethnology as a special field collector. Professor Frederick W. Putnam, curator of Peabody, was one of Abbott's loyal supporters and upheld his theory of Stone Age Man in New Jersey. The extent of Professor Putnam's admiration was indicated by the fact that an entire gallery in the Peabody is devoted to Abbott's collection of Indian and prehistoric artifacts from the Delaware Valley. Dr. Abbott then accepted a position as the first curator of the Department of American Archaeology[7] in the University of Pennsylvania's newly founded Museum (1890-1894).

Charles Conrad Abbott was a member of many learned scientific societies, including the American Philosophical Society and the Boston Society of Natural History. He was not a member of The Medical Society of New Jersey, presumably because of his great activity in other scientific societies. But he always proudly signed his name *Charles Conrad Abbott, M.D.*

Dr. Abbott married Julia Boggs Olden on February 13, 1867 in Princeton. She was born May 23, 1846 and educated in schools in Princeton. Her father was treasurer of Princeton University until he died in 1876. An uncle, Charles S. Olden, was Governor of New Jersey during the Civil War.

Charles and Julia Abbott had four children: Maria Olden Abbott, born in 1867, died in 1956; Richard Mauleverer Abbott, born in 1871, died in 1943; Julia Boggs Abbott, born 1876, died 1956, and Arthur Brinton Abbott, born in 1883, died in 1886.

Richard was also a farmer. As soon as he became of age he was placed in charge of the farming operations of *Three Beeches*. Of all the children, Richard seems to have had the strongest inclination toward science. Trained in archaeology by his father, Richard was often a partner in Dr. Abbott's archaeologic investigations of the Delaware Valley. Richard contributed specimens to the Peabody Museum in Cambridge during the time Dr. Abbott was associated with that institution. He never achieved the distinction in science as did Dr. Abbott, partly because of his involvement in the management of the Abbott farm, and partly because of his disillusionment caused by the bickering of scientists over Dr. Abbott's claims of primitive man in New Jersey. Richard's son, Charles Conrad Abbott II lives in West Chester, Pennsylvania with his family. He is a seed analyst, working in quality control, for a large mushroom concern.

Dr. Abbott supported his family mainly through the income derived from the books and articles he wrote. He was a prolific writer, and his bibliography comprises over two hundred titles, ranging from erudite discussions of archaeology and natural science to shy attempts at poetry. Other than that, a small inheritance and the income from the farm products of *Three Beeches* held the family together. Additional sources of income were the scientific positions of varying influence and affluence Dr. Abbott held. He was never wealthy. His total immersion in his own scientific pursuits, and his restless nature, prevented him from conforming to the image of the typical breadwinner of a large family.

In 1919, at the age of 76, Dr. Abbott died from nephritis. He is buried in Riverview Cemetery, Trenton.

Though several New Jersey physicians certainly deserve a similar tribute, few doctors have achieved the distinction of having their homestead designated an historic site. Charles Conrad Abbott, M.D. earned this honor by his cataclysmic contributions to nineteenth century American science. His concepts of early *Homo Sapiens* in New Jersey electrified the gaslight era of science and illuminated the way to the development of the then infant sciences of anthropology and archaeology.

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This thought-provoking review will get most of us thinking about matters we had not heard of since second year medical school.

The Polar System Of Integration:

The Germ-Layers, Nerves And Endocrines—The Pituitary And The Pineal

Harold E. Lippman, M.D./South Orange

In all organisms, development or malformation, health or disease, life or death depends upon the mode of function of interlocking, interdependent and, at the same time, opposite and antagonistic systems of integration. These are based upon protoplasmic structures and functions polarized as "animal" or "vegetal." In man the "animal" is represented by the central, peripheral, autonomic, and enteric (visceral) nervous systems, muscles in all their locations, the ectodermal components of the skin, and the ciliary nets of various epithelia—structures basically ectodermal. The "vegetal" is represented by endocrine glands, glandular components of the gastrointestinal tract, respiratory, excretory, and osmoregulatory tissues and cells and the like — structures primarily endodermal.

Ectoderm and endoderm, the primary germ-layers, may be traced from the "animal" and "vegetal" poles of the ovum. The ectoderm is more "animal," less "vegetal," the endoderm, more "vegetal" and less "animal." The inner essence of development lies in the interaction of these opposite and interdependent germ-layers. However, the broader principles of "animality" and "vegetality" transcend the germ-layers and may be applicable even to organs in which both layers are represented.

All living processes entail varying degrees of these opposites. Animality is sensibility, responsiveness, motility and decision (psychic function). Vegetality is nutrition, excretion, secretion, osmoregulation, and so on. This constitutes an interpenetrating polarity that, I think, could help solve many of the outstanding problems of medicine and biology. Three concepts, that it seems to me are erroneous, obscure the recognition of this polarity. These are, first, the metaphysical notion that the cell is an absolutely independent unit wherever it is found; second, the erroneous idea that the "mesoderm" is a primary germ-layer; and third, the unsubstantiated, antiphylogenetic belief that the adenohypophysis is ectodermal.

Among the earliest records of man may be found awareness of the basic cleavage in life, the differences between plants and animals. With the development of the sciences came identification of the differences as well as the recognition of numerous polarities basic to physics, chemistry, and biology. These include the relations of matter and energy, electrons and protons, metals and non-metals, and the acids and bases. In living organisms, cytoplasm and nucleus, hyaloplasm and deuteroplasm, ectoderm and endoderm came to be recognized — the first of each pair being "animal," the second, "vegetal." Ultimately changes in the states of matter came to be associated with interactions of opposite factors on successively higher levels.

In 1815, Hartmann[1] advanced a polar theory of life and disease. Thirteen years later, von Baer used the terms "animal and vegetal" to describe the germ layers. Hartmann[1] wrote that "Life is the product of opposing forces rather than of a single life-force of unknown nature. . . . Life manifests itself in two ways;

as a formative (*bildendes*) vegetative process, and as a motile (*bewegendes*) process." He classified diseases into vegetal (Vegetationskrankheiten) and animal (Erregungskrankheiten) types. In modern medicine echoes of such polar ideas on a more mechanical level may be found in works by Crile[2] and Pottenger.[3]

In biology von Baer's germ-layer polarity followed Cuvier's description of the external and internal walls of the coelenterate polyp. In 1849, Huxley[4] described in the Medusae two distinct membranes ". . . the outer becoming . . . the muscular system . . . organs of offence and defence; the inner . . . subservient to the purposes of nutrition and generation." Polar concepts continued to develop in the ideas of Kleinenberg,[5] Kowalevsky, Lankester, Agassiz, and others until the time of the popularization of the Darwinian idea of evolution.

The popularity of Darwin's theories had, by 1870, led to a rejection of this "polarity" idea. Polarity was in obvious conflict with the popular concept of a slow (almost infintely slow) evolution based on the inheritance of small, chance variations. Polarity favors ideas of sudden metamorphoses (see especially Agassiz) like tadpole to frog, larva eto adults, caterpillar to butterfly. Embryology was regarded as a recapitulation and the Darwinists felt impelled to mold it to their ideas of how evolution happened. The animal-vegetal and ectoderm-endoderm polarities (intrinsically transformative) had to be sacrificed for the victory of mechanical materialism over clericism.

Darwin's first lieutenent, the astute and eloquent Huxley (who both before and after the publication of the *Origin of Species* affirmed his belief in the possibility of metamorphic change) sacrificed his own contribution — the polar layers in Medusae — and introduced in 1871 the term *mesoderm* for the inner layers of the organism. Another eminent campaigner for Darwinism, Francis M. Balfour[17] carried the concept a step further insisting that the "mesoderm" originated as a separate layer from the lips of the blastopore and was therefore an independent primary germ-layer. This assertion is today entirely discredited.

Kleinenberg[5] as the result of meticulous work on the annelid Lopodorhynchus (1886) disputed Huxley[4] and Balfour.[17] The in-between

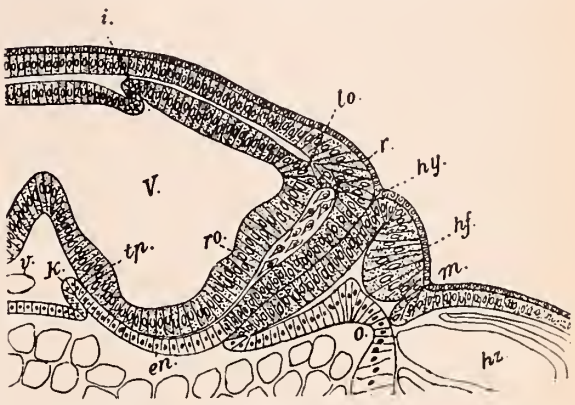


Figure 1.

From Kupffer 1892: Notice the identation "hy." The entoderm "en" is closely applied to the infundibulum and is continuous wtih a canalicular structure (Rathke-Seessel or Nusbaum's canal) which leads to the indentation "hy." This tissue runs beneath the external ectodermal layer and is continuous with the suction disc "hf" which is known to be endodermal. Note also the pouch structure "k." This is the posterior pharyngeal pouch or "Gaumentasche" (Salenka). This contributes to the ependyma of the brain and to the pineal, labeled "i."

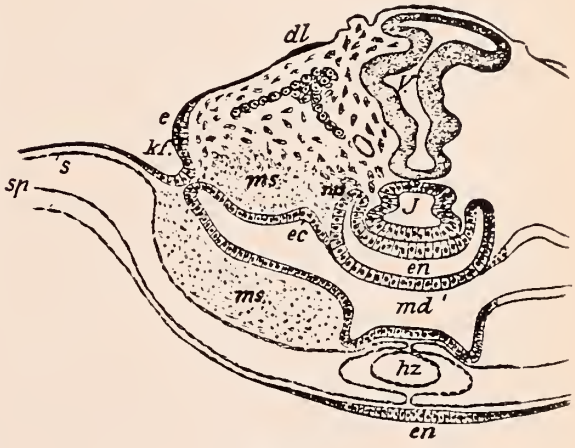


Figure 2.

From Kupffer 1894: In this cross section of the head of the embryo of Bellastoma the infundibulum is labeled "J." The hypophyseal area is labeled "en" (for endoderm) which like the hypophysis in numerous species builds itself around the neurohypophysis or infundibulum.

tissues he showed originated either from endoderm or ectoderm and were therefore *mesendoderm* or *mesectoderm*. In a similar stand Hertwig[6] (1883) asserted that "two things which are genetically, morphologically, and histologically entirely different" were

confused in the conception "middle germ-layer." In modern embryology the terms mes ectoderm and mesendoderm are again in use.

The polar concepts "animal" and "vegetal" are in use in contemporary embryology. Applicable to submicroscopic bits of protoplasm on the one hand (Andrews[7]) and macroscopic systems of integration on the other (Hughes[8]), this polarity encompasses, but is much broader than, the concepts of the ectoderm and endoderm. The understanding of the range of this A-V polarity includes knowledge of cytoplasm and the nucleus, the hyaloplasm and the deuteroplasm, and the phenomena of "sensory-dominance" and "induction." Animality includes sensation, the psychic functions (decision etc.), response, and motility. Vegetality includes nutrition, excretion, secretion, absorption, osmoregulation (metabolism).

The analysis of the interpenetrating embryology of the two primary germ-layers, the *endoderm* and the *ectoderm,* illuminates the *animality-vegetality* polarity. These words therefore have the greatest heuristic value. The term "mesoderm," in ignoring the basic developmental differences on the cellular level, is a prime source of confusion in biology, embryology, and medicine.

The organismic polarities take on aspects of conflict as well as cooperation. The eminent embryologist, Roux,[9] recognized this, entitling his main work *Der Kampf der Teile das Organismus.* It is well known that certain conditions as well as certain ions (lithium, for instance) stimulate the development of one tissue while inhibiting its opposite. The sensation of the condition or ion, the "animal" function (itself metabolic) results in a basic metabolic change, the "vegetal" function. Animality depends upon vegetality, ectoderm on endoderm. Yet endoderm "stuff" is found in the ectoderm and ectoderm "stuff" in the endoderm. The development and nature of the organism depends on both the similarities and the differences.

The father of experimental embryology, Roux[9] (a pupil of the mechanist Goette), in his 1880 work listed nine autonomous or "self" directed functions of organisms — excretion, ingestion, assimilation, movement, growth, development, change, multiplication, and transmission of hereditary characteristics. Although implicit in the phrase "self-directed," the terms "sensation" and "psychic functions" were conspicuously absent from this list. These added to "movement" constitute "animality." Excretion, ingestion, and assimilation are major aspects of "vegetality." The remaining functions result from the interaction of the "animal" and the "vegetal." Roux came close to the recognition of A-V polarity and it may be concluded that this played some role in the genesis of experimental embryology.

The just-fertilized egg possesses animal and vegetal poles. "Animal" functions are most closely associated with "animal" structures: the clear hyaloplasm. After acquiring nuclear material (vegetal) much of the animal pole hyaloplasm splits off to form a cap and then a cover of micromeres, the "animal" ectoderm layer that surrounds a core of "vegetal" macromeres and related endoderm. This is equivalent to Huxley's "polyp" and to the free-living ciliated "planulae" which Agassiz found in the larval stages of representative species of most of the phyla including various chordates (Amphioxus and others.) In ciliated areas, such as the ectoderm of the various planulae (and even differentiated epithelia), coordination has been found to be based on intercellular processes of a "neuroid" or nerve-net nature. That intercellular bridges are found in ectodermal skin tissue, the syncetial voluntary and cardiac muscles, nerve-nets and "neurones" seems to point to a primitive syncetial condition of the micromeres as the ancestral condition. The intercellular bridges, the syncetia, the nerve-net structures, the fibrils that arise from neurones and penetrate into the very nuclei of other cells (smooth muscles, certain liver and skin cells etc.) are all different aspects of protoplasmic continuity that enables better communication and hence more efficient animal function.

The protoplasmic continuity of the ectoderm and its derivatives stands in opposition to the

discreteness and relative individuality of endodermal cells. Blood cells, gland cells, fibroblasts, the endoderm of all organs and the glia, astrocytes, oligodendrites and Schwann cells of the brain and nervous system are all non-syncetial. (Giant cells are exceptional in endoderm).

The endoderm gives rise to all the endocrine glands. Phylogenetically, Brien[10] has stated that the gastric layer of the Hydra (endoderm) functions as endocrine tissue. In vertebrates thyroid, parathyroid, adrenal cortex, gonads, and the glandular elements of the gastrointestinal tract are conceded to be endodermal. However, textbooks assert an ectodermal origin for the adenohypophysis. Yet many investigators such as Reichlin[11,12] and Frauchiger[13] have concluded on clinical and other grounds that the adenohypophysis is endodermal. According to Clark[14] and Woollard,[15] the hypophysis originates within the prochordal plate which is admittedly endodermal.

Beginning with Rathke himself, and until 1873, almost all biologists insisted that the hypophysis was endodermal. However the Darwinists Goette[16] and Balfour[17] and Mihalkovics[18] found that the opening of Rathke's pouch was *external* to the oral plate from which they concluded that the pouch itself was ectodermal. The finding was correct but the conclusion was erroneous. In Amphioxus[19,20,21] and in certain vertebrates[22,23] it has been demonstrated that *an endodermal canal* opens to the exterior at the edge of the oral plate (see illustration from Kupffer). His-

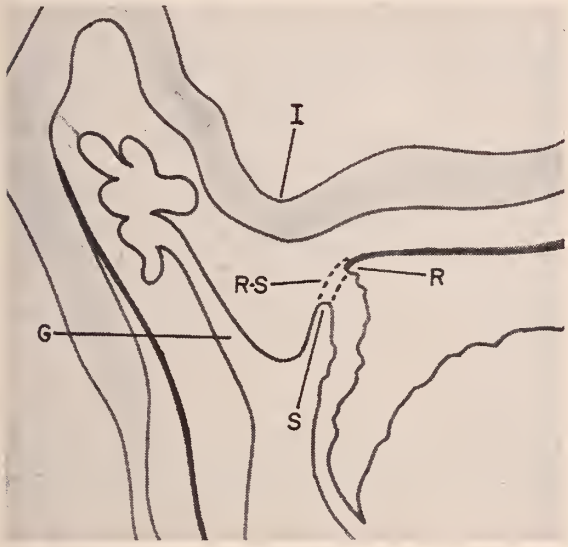


Figure 3.

Modified with respect to the hypophysis and the R-S canal from Salenka 1887. The canal R-S is dotted in to represent the developmental anterior prochordal plate canal. This is analogous to the pre-oral pit of Amphioxus. Note the close correspondence with the canal in Kupffer's drawing, figure 1. "G" is the posterior pharyngeal or posterior prochordal plate canal. It corresponds to "k" in Kupffer's figure and to the club-shaped gland of Amphioxus.

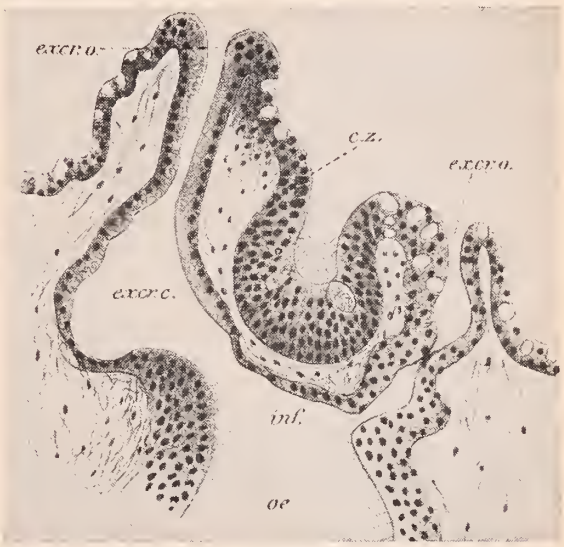


Figure 4.

Mortensen 1912: This is a section through the apical region of the embryo of the ctenophore Tjalfiella Tristoma. Here the U-shaped dorsal sense organ represents the ancestral brain, especially the archencephalon and infundibulum. Like the vertebrate infundibulum as illustrated in our figure #3 it is bordered on two sides by glandular endodermal canals. In the ctenophore these are called the "anal" or "excretory" canals. The openings of these are ciliated and they apparently function much like the pre-oral pit or club-shaped gland of Amphioxus—more secretory than excretory. The two endodermal canals are ancestral to the twin adneural glands in the invertebrates and to the adenohypophysis and the glandular elements of the pineal in the vertebrates.

tologic and embryologic studies confirm the basic similarities of adenohypophyseal[15] and prochordal plate endoderm.[24,25,26]

It may therefore be concluded that the two major systems of integration of the vertebrate (the central nervous system and the endocrine system) are derived from *opposite* germ-layers. The conductive elements of the nervous system derive from syncetial ectoderm; the endocrine secretory tissues from

cellular endoderm. Both the two opposite systems and the two opposite types of protoplasmic structures of which they are composed are interdependent. The nervous system requires endoderm just as the endocrines require ectoderm. The synapse is best understood as an osmoregulatory system dependent on the living functions of the endoderm associated with the nerves.

Knowledge of the germ-layer of origin of the cells and tissues is essential for the understanding of the neuromuscular system and the endocrine system. It is also a prime requisite for understanding the structure and functions of *all* organs. In development and in the genesis of disease, interactions of the "animal," "sensory dominance" factors with the "vegetal" or "inductive" factors play the central role. The importance of this is seen in the very structure of tissues and organs. The gastrointestinal tract and the central nervous system are commonly thought of as endoderm and ectoderm respectively. Closer analysis shows that combinations of both polar layers form these organs! The most sensitive "animal" cell requires "vegetal" support; the most metabolic "vegetal" cell requires "animal" support.

Ectoderm invaginates into the blastopore (the cloacal region) in embryogenesis. The sacral innervation parallels this and innervates the smooth muscles that develop from this invaginated ectoderm.

In the brain, the conductive neural tissue derives from syncetial ectoderm, but needs the osmoregulatory and nutritive support of endodermal cells. The secretion of the cerebrospinal fluid is a function of the osmoregulatory and glandular endoderm of the choroid plexuses.

The endoderm of the glandular structures of the brain and head may be traced to the prochordal plate. When the first endoderm cells are delaminated at the blastopore they penetrate the archenteron until they come to lie under the apical micromeres which are then transformed into the medullary plate, while this endoderm itself[27] becomes the prochordal plate.[28] In the anterior part of the prochordal plate an anterior canal, the Rathke-Seessel canal of Nusbaum[29], develops. This is analogous to the endodermal pre-oral canal of Amphioxus. From this Rathke-Seessel canal, the adenohypophysis develops and endoderm enters into the brain through the anterior neuropore. From the posterior part of the prochordal plate the posteior[30] pharyngeal pouch[31] develops. This is analogous to the club-shaped gland of Amphioxus and from the anlage of this pouch the glandular elements of the pineal[32] and of the other so-called "roof-glands" develop.

The existence of two endodermal pouches in the prochordal plate of the vertebrate corresponds with the fact that in *all* cephalized invertebrates (from the Ctenophore up) two endodermal adneural glands develop. Thus, phylogenetic common origin explains the similarities in the glandular elements of the pineal and the pituitary.

The situation of the pituitary in the head is consonant with its role as "leader" of an endodermal endocrinal system. The adjacent archencephalon is the ectodermal "leader" of the nervous system. These two systems are interpenetrated and integrated in both structure and function. The organism is a unity built from two opposite and interpenetrating principles recognizable at various levels as "animality-vegetability," ectoderm-endoderm, ectoplasm-endoplasm, cytoplasm-nucleus, and hyaloplasm-deuteroplasm. The "animal" ectoderm tends to be syncetial; the "vegetal" endoderm tends to be composed of discrete cells. At every level, these are at once antagonistic and cooperating opposites. The recognition of these opposing pairs and of the nature of their oppositions may enlighten medicine regarding the real nature of disease processes, development and malformation, and life and death. In addition, the intra-organismic polarities add weight to the evidence favoring a relatively sudden metamorphic origin[33] and corresponding embryologic development of the human species.

A bibliographic listing of 33 supporting citations will be found in the author's reprints.

306 Warwick Avenue

STATE ACTIVITIES

Trustees' Minutes

September 17, 1967

A regular meeting of the Board of Trustees was held on September 17, 1967, at the Executive Offices. For your further information, detailed minutes are on file with the Secretary of your component society. A summary of the significant actions follows:

Volunteer Physicians For Viet Nam . . . Directed that correspondence from the AMA urging continuing support of its "Volunteer Physicians For Viet Nam Program" by each state society be noted, and referred to THE JOURNAL for possible comment.

Disaster Medical Problems . . . Designated R. Winfield Betts, M.D. of Medford as MSNJ's official representative to a symposium on the "Management of Trauma and Disaster Medical Problems," to be held in Miami on November 10 and 11.

Emergency Medical Services . . . Designated Jack R. Karel, M.D. of Hillside as MSNJ's official representative to the national conference on "Community and Emergency Medical Services," to be held in San Francisco on January 18, 19, and 20, 1968.

Rule 4:25B (Subpanel under Administrative Office of Courts) . . . Directed that physician-members of a subpanel, who are called upon to consider a matter which previously they had dealt with as members of a medical review and advisory committee, disqualify themselves for subpanel service on that particular matter.

Revised Rule 4:25A and 4:25B . . . Directed Legal Counsel to submit for publication in THE JOURNAL a statement which would be an admonishment that physician-members and attorneys should not be qualified or referred to as members of either the Impartial Medical Panel or the Professional Liability Panel, and that, although membership on either is to be considered as an honor, it is not in any way to be construed as a certification by the Supreme Court of their qualifications.

Legislation . . . Approved the following recommendations of the Council on Legislation:

1) Current State Legislation:

A-751—To define trademark and the counterfeiting thereof concerning drugs, cosmetics, and devices; to place enforcement in the Department of Health. *APPROVAL*

A-811—To provide that ear-piercing shall be construed as the practice of medicine and surgery. *NO ACTION*

A-900—To repeal the unemployment compensation and temporary disability benefits act. *APPROVAL*

2) Introduction of New Legislation:

That the policy decision of MSNJ not to introduce any other legislative measure until some positive action was taken by the Legislature with regard to the medical/X-ray technicians' bill be rescinded. The Council on Legislation is now empowered to consider measures according to its appreciation of the priority of importance and timeliness of such introduction.

3) Utilization Review Committee Immunity:

That the following draft of a proposed bill be approved for introduction in the Legislature at the appropriate time (according to a mandate of the 1967 House of Delegates that MSNJ seek passage of state legislation which would provide a physician, who serves on a utilization review committee, immunity from litigation arising from the actions of the committee):

AN ACT relating to the confidentiality of information and data secured by and in the possession of utilization review committees.

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

1. Information and data secured by and in the possession of Utilization Review Committees established by

any certified hospital or extended care facility to comply with the provisions of the federal Social Security Act in the performance of their duties shall not be revealed or disclosed in any manner or under any circumstances by any member of such committee except to a patient's attending physician and the chief administrative officer of the hospital or extended care facility which it serves, or representatives of government agencies in the performance of their duties, under the provisions of Federal and State Law.

2. No member of a Utilization Review Committee may be held liable for damages or otherwise prejudiced in any manner by reason of recommendations or findings made by said Committee or for furnishing information or data obtained in the course of his duties as a member of a Committee to the persons and officials mentioned in Section 1 hereof.

3. This act shall take effect immediately.

Public Relations . . . Approved the report of the Council on Public Relations which listed the following continuing projects for 1967-68:

1) Publication and distribution of:

(a) *Junior Health Hints* to schools and public libraries

(b) *Membership News Letter,* including the annual compilation of a bound, indexed set to component societies

(c) *Periodic Newsletter* to cooperating agencies and individuals

2) Preparation and publication of special news releases and publicity as required from time to time, in furtherance of the Society's business and interests, including:

(a) 1967 eye health screening program

(b) 1968 annual meeting

(c) Child Safety Week

(d) Selected official programs and activities

3) Responsibility for bestowal of the Golden Merit Award

4) Responsibility for the press room at the annual meeting

5) Encouragement—or establishment—of orientation programs for new members under the sponsorship of component societies

6) Encouragement of statewide emergency medical care coverage, particularly with reference to the "Basic Concepts Underlying the Provision of Professional Medical Care" as adopted by the House of Delegates

7) Encouragement of Future Physicians Clubs in each county through service as a clearinghouse at state level.

Morris County Medical Society—Fees For Medical Services . . . Agreed that its view is that a bill from a hospital facility, as presented to a patient, should reflect the charges assigned to physicians as different from other groups or facilities participating as a team; and directed that all interested parties be so informed.

Cardiac Advisory Panel . . . Directed that Harry Kaplan, M.D. of Trenton be recommended to the Director of the Division of Motor Vehicles to fill the vacancy on the Cardiac Advisory Panel created by the resignation of Louis F. Albright, M.D.

Support of JEMPAC . . . Directed that the following information be reflected in THE JOURNAL or *News Letter,* whichever can best accommodate the item:

That attention be called to the AMA resolution adopted by the 1967 House of Delegates urging leaders and members of local organizations to continue support of their own state PAC, as well as AMPAC.

That the Board reiterates its encouragement of members, as individuals, to join and support both JEMPAC and AMPAC, and called attention to its recently appointed conference committee (June 25, 1967) whose purpose is to improve communication and exchange ideas with JEMPAC.

AID Program . . . Approved a list of recommended extended maximum limits of stay for certain of the listed diagnoses on AID, and a list offering new diagnoses and durational maximums not thus far included in the AID schedule, to be forwarded, with a covering memorandum, to hospital administrators, presidents/chiefs of staff of hospitals, and chairmen of utilization review committees.

AMA Clinical Session . . . Elected Robert E. Verdon, M.D. of Cliffside Park as the Society's alternate-delegate to the AMA Clinical Session, November 26 to 29 in Houston; and authorized the following to attend the session, with expenses paid: President, President-Elect, Executive Director, seven delegates and one alternate-delegate.

Houston Headnotes

Keeping abreast of scientific and other activities and reaching those sometimes-difficult decisions as to which exhibits or other Convention programs to concentrate upon will be greatly simplified for those of you lucky enough to attend the AMA Clinical Convention in Houston, November 26 to 29. Here the great simplifier is "Hotelevision," a closed-circuit television system which will feature 40 hours of diverse programing on Convention activities. From their rooms in hotels and motels, physicians and their families can watch the daily telecasts on a specially designated channel during "off" Convention hours — 7 to 9 a.m. and 5 p.m. to midnight.

"Hotelevision," tried on an experimental basis by the AMA at the Convention in our state last June, adds a refreshing, new dimension to Convention communications coverage. It has been included as a permanent part of Annual and Clinical Convention programing as the result of highly favorable response in a survey conducted among 1,500 physicians who pre-registered to attend the Annual Convention.

Although little advance publicity was given to the "Hotelevision" programing, 43 per cent of the physicians participating in the survey stated that they watched at least one program on one of 11,000 sets receiving the special Convention programing in 67 hotels and motels along the Atlantic City Boardwalk. This ratio was considered high since a significant number of the physicians in the test group did not stay in one of these hotels or motels, or attended the Convention for only a single day. The overwhelmingly favorable aspect of the survey, however, was that more than 90 per cent of those who tuned in on the "Hotelevision" channel liked the programing and considered it a valuable addition to the Convention. The typical viewer tuned in on three of the five Convention days.

While "Hotelevision" is not an innovation, the AMA version is unique since subject matter must appeal to an audience of diverse interests, rather than to one having a single interest. Functioning somewhat as a daily bulletin of the air, the closed-circuit television schedule, featuring 70 separate shows, is designed to complement or emphasize Convention activities. It does not compete with them.

Scheduled along with programs highlighting scientific and other Convention activities; local, national, and world news; cultural and other attractions in the host city are a variety of educational and entertaining shows dealing with topics of particular interest to physicians.

One of the most popular programs at Atlantic City last June was *Open End,* a panel show following the 10 o'clock news. Viewers capitalized on the opportunity to telephone questions to panel members. There were panels on medical education, legislation, and research. Another popular show was *Medical Bowl,* a quiz show in which physicians representing four sections of the country competed. Questions tested knowledge of government legislation, including Medicare, in particular.

The American Academy of General Practice found six of the shows so informative that they included the videotapes in *their* television programing at the AAGP convention in Dallas in September.

Richard M. DuMont, director of the AMA's Department of Radio, Television, and Motion Pictures, said the same kind of format would be repeated at Houston.

The AMA's "Hotelevision" programing is sponsored by pharmaceutical houses, who purchase commercial time in 32-minute packages. This is a new facet of AMA Convention marketing for pharmaceutical houses, augmenting their exhibits, daily bulletins, and other convention-oriented advertising.

Volunteer Physicians For Viet Nam

The American Medical Association calls attention to the program of "Volunteer Physicians for Viet Nam." In all, some 293 doctors have embarked on this 60-day tour of service. With four exceptions (Alabama, Delaware, Rhode Island, and Mississippi) every state is represented in the honor roll of participants. From New Jersey, only two (Dr. S. W. Kalb of Newark and Dr. F. E. Gilbertson of Red Bank) have volunteered. Among states with a smaller physician-census than New Jersey, the contributions to this have generally been larger. From the State of Washington came 15, from South Carolina 12, from Indiana 11, from Colorado 9, and so on.

Some 40 physicians at a time are needed in this program in Viet Nam. Right now there is need for ophthalmologists, orthopedists, surgeons, internists, pediatricians, and general practitioners. Current programing calls for the continuing recruitment of 32 volunteers every sixty days. Forty physician volunteers can be effectively utilized in Viet Nam at any one time. As the need for specialists increases, it is anticipated that the AMA will have a requirement for 50 volunteers every 60 days. To meet this goal of 300 volunteers in 1968 will require the vigorous and continuing support of the program by every state medical society. By now 275 volunteers have returned from Viet Nam and are considered alumni; this number does not include the 32 currently in Viet Nam nor the volunteers who have served a second tour. These alumni could form a recruiting nucleus in each state.

This program is financed by the United States Agency for International Development, and administered by the American Medical Association. Physicians sent to South Viet Nam under the program serve a 60-day tour of duty at civilian hospitals. The volunteer receives only his transportation and an expense allowance of $10 a day.

At the request of President Johnson, the volunteer physician program was initiated in August 1965. The American Medical Association had assisted in the recruitment of physicians for the project throughout its entire operation. Over three hundred physicians have participated in the program since its inception. One out of every 1000 licensed physicians in the United States has voluntarily provided, under this program alone, over 50 man-years of medical care to the civilian population of South Viet Nam.

If you are interested, write to the Executive Offices at P.O. Box 904, Trenton 08605.

Communicable Diseases In New Jersey

A patient at an Elizabeth hospital was diagnosed as having undulant fever caused by *Brucella abortus.* It is believed that he became infected by drinking raw milk in Puerto Rico. The patient has been hospitalized for several months as a result of this illness. Brucellosis eradication efforts in dairy herds (and State regulations requiring the pasteurization of milk and milk products) have virtually eliminated this cause of undulant fever in New Jersey. Two cases of undulant fever caused by *Brucella suis,* however, have been reported during the last twelve months. These were associated with contact with swine. The absence of regulations controlling brucellosis in swine herds has left this source of infection as a continuing hazard for occupationally exposed personnel.

Four fatal cases of lead encephalopathy occured in Negro and Puerto Rican children, between 19 months and 3 years of age in Paterson last month. Primary symptoms included vomiting and lethargy. The diagnosis was confirmed by tissue examination for lead. Three of the children had history of pica. The source of lead is presumed to be ingestion of paint. Presently under discussion is a screening program for chronic lead poisoning in pre-school children in Paterson.

A southern New Jersey family of six was investigated after four members were clinically diagnosed as having Rocky Mountain spotted fever. There was a history of heavy tick infestation of the pet dog and in the house. There was laboratory confirmation (Weil Felix or complement fixation test) on two of the family members and the dog. Sixteen cases of Rocky Mountain spotted fever have occurred among New Jersey residents so far this year. This is higher than any previously recorded annual incidence.

Summary Of Notifiable Diseases

	August 1966	*August 1967*	*Cumulative 1967*
Aseptic meningitis	6	21	82
Brucellosis	1	1	2
Primary encephalitis	5	2	20
Total hepatitis	70	114	976
Infectious hepatitis	53	102	871
Serum hepatitis	17	12	105
Malaria	0	2	61
Measles	3	5	401
Meningococcal meningitis	13	5	92
Psittacosis	0	0	2
Rocky Mountain spotted fever	1	2	16
Salmonella	57	29	320
Shigella	7	6	107

Objections To S. 2299 And S. 17

Parke, Davis and Company recently sent to Senator Long the following letter concerning two bills on control and pricing of drugs:

The Honorable Russell B. Long
Chairman, Senate Finance Committee
Washington, D.C.

Sir:

As a pharmaceutical manufacturer with over 100 years experience in supplying the medical profession, pharmacists, and the consuming public with dependable products, Parke, Davis and Company wishes to offer some comments with respect to Senate Bills S.17 and S.2299, currently being studied by the Senate Finance Committee.

Although the title of S.2299 suggests the establishment of standards of quality and costs for drugs, the bill is essentially one dealing with price controls. *Nowhere in the bill is there a provision for quality standards for drugs in general.* An amendment of the title of the Act is needed.

The bills contemplate a "Formulary Committee" and the compilation of a "Formulary of the United States." The names of the proposed committee and the publication are misleading. A "Formulary" is supposed to be a book containing a list of medical substances and formulas, together with standards of identity, strength, quality, and purity. The compilation to be produced by the committee is simply a list of drugs and their recommended price ranges which the committee has selected as qualifying for benefits under the Social Security Act. This is not a formulary.

No single committee, whether it be a governmental or other body, should be given the *sole authority* to decide what drugs are necessary or proper to diagnose or treat disease. Both bills propose to entrust this respnsibility to the "Formulary Committee." This will interfere with the duty of the physician to exercise his best judgment in selecting products he considers most effective in treating his particular patient.

If adopted, these bills would be a detriment to people on Social Security because they may be denied the right to obtain drugs of the highest quality, potency, and effectiveness. The physician should be permitted to prescribe for his patients those drug products which from his personal experience, have proved to be safe and effective for their needs. The health of his patients should not be jeopardized by procedures which could induce him to prescribe inferior products simply to save his patient some expense. In this connection we direct this Committee's attention to Senator Nelson's recent remarks before the Monopoly Subcommittee of the Select Committee on Small Business, when he said:

"I know of nobody I ever met in the United States who would require a doctor to prescribe generic drugs and not permit him to designate the company whose product he wishes. I don't believe anybody would support that."

The bills being studied would result in the very situation Senator Nelson has advised against.

The bills contemplate testing procedures to determine which drugs are to be in the "qualified" list. It is intended that approval of drugs shall be based solely on whether they contain specific chemical compounds, erroneously ignoring the fact that such drugs may not have the same clinical effectiveness as others containing the same chemical compounds. Different pharmaceutical products containing identical chemical compounds do not necessarily have the same degree of clinical effectiveness. We are prepared to produce proof that certain generic products (offered as copies of one of our products) are in fact not equal in quality nor in their anticipated effect. The experience of other reputable pharmaceutical manufacturers would provide similar evidence to support this position.

Both bills are fundamentally designed to be price control measures. Legislation intended to control prices of consumer commodities is inequitable, has never been successful, is fundamentally in conflict with the American economic system, and can be justified only as a temporary war-time expedient, if in fact it can be justified at all.

Senate Bills 17 and 2299 would restrict the practice of medicine, harm the people they are intended to help, and be incompatible with our basic American principles. We urge that they *not* be adopted in their present form. Our existing system is not perfect but it has been highly effective in raising our nation to the highest standard of health in the world. We respectfully suggest that free and open competition, which has in large part contributed to this result, should not be replaced by government controls, as presently visualized in this legislation.

Very truly yours,
Parke, Davis and Company
Kenneth D. McGregor
Secretary

OWNERSHIP STATEMENT

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

(Act of October 23, 1962; Section 4369, Title 39, United States Code)

1. Date of Filing: September 26, 1967.

2. Title of Publication: THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY.

3. Frequency of Issue: Monthly.

4. Location of known office of publication: 315 West State Street, Trenton, New Jersey 08618.

5. Location of the headquarters or general business offices of the publishers (Not printers): 315 West State Street, Trenton, New Jersey 08618.

6. Nomes and addresses of publisher, editor, and managing editor. Publisher, The Medical Society of New Jersey, 315 West State Street, Trenton, New Jersey; Editor, Henry A. Davidson, MD., 315 West State Street, Trenton, New Jersey.

7. Owner (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given.): The Medical Society of New Jersey, 315 West State Street, Trenton, New Jersey. (a non-profit corporation of New Jersey).

8. Known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgoges or other securities (If there are none, so state): None.

9. Paragraphs 7 and 8 include, in cases where the stockholder or security holder appears upon the books of the company as trustee or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting, also the statements in the two paragraphs show the affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner. Names and addresses of individuals who are stockholders of a corporation which itself is a stockholder or holder of bonds, mortgages or other securities of the publishing corporation have been included in paragraphs 7 and 8 when the interests of such individuals are equivalent to 1 percent or more of the total amount of the stock or securities of the publishing corporation.

10. Extent and nature of circulation:

	Average No. copies each issue during preceding 12 months	Single issue nearest to filing date
A. Total No. copies printed (Net Press Run)	7,901	7,859
B. Paid Circulation		
1. Soles through dealers and carriers, street vendors and counter sales		
2. Mail Subscriptions	7,545	7,502
C. Total Paid Circulation	7,545	7,502
D. Free Distribution (including samples) by mail, carrier or other means	333	333
E. Total Distribution (Sum of C and D)	7,878	7,835
F. Office use, left-over, unaccounted, spoiled after printing	23	24
G. Total (sum of E & F—should equal net press run shown in A)	7,901	7,859

I certify that the statements made by me above are correct and complete. Richard I. Nevin, Executive Director
The Medical Society of New Jersey

The Vanishing Nurse

The full dimensions of the nursing shortage in the United States are revealed in a fact sheet prepared by the National League for Nursing. This says that there are 621,000 professional nurses employed today while the need is for 746,000 — a shortage of 125,000. "Authorities set the goal for 1970 at 1,000,000 active RNs," says this summary. "The shortage can reach some 344,000 — more than one-third the total need — in three years. This means thousands of budgeted staff vacancies in hospitals and clinics, insufficient and improperly prepared faculty in many nursing education programs, and inadequate nursing for the American public." A shortage of licensed practical nurses also exists. The total number now working is 282,000, while the need is for 311,000.

"The number of practicing registered nurses has increased tremendously in the last ten years — from 430,000 to 621,000. No other profession has grown more rapidly. But events have out-stripped the growth. The population explosion plus the growth of health insurance, and the advent of Medicare and Medicaid have increased the demand for nurses. Also, more highly specialized knowledge is required of the nurse. Nursing responsibilities have increased proportionately to the increase in medical knowledge and technics. Physicians rely increasingly on professional nurses to help bring new surgical technics, chemotherapy treatments, and rehabilitation methods to patients. This, in turn, means that a larger number of nurses with college degrees are needed for expert patient care, for supervisory posts in hospitals and clinics, and for teaching and administration."

The National League for Nursing conducts programs across the country to encourage community action for the improvement of nursing services and nursing education. It accredits schools of professional and practical nursing and public health nursing agencies. It provides services for evaluating the potential of pre-nursing students and the educational achievements of nurses and nursing students. Licensure tests for professional and practical nurses in the United States and Canada are prepared, distributed, and scored by the League.

Medical License Figures—1966

Another 8,596 licensed physicians were added to the United States medical profession in 1966, according to a report by the American Medical Association's Council on Medical Education. As of January 1967, there were 300,376 physicians in the U.S. This includes 243,391 licensed physicians, a net gain after deaths and retirements of 3,768 licensed physicians from the same date a year earlier. In addition to these M.D.s, there were thousands of physicians working under medical, educational, and military-service permits—including most interns and some residents, as well as other government-service doctors. In all, some 267,000 physicians were involved in patient care.

The number of initial licenses decreased eight per cent in the New York-New Jersey-Pennsylvania area. Part of this decrease was due to a decline in the number of foreign physicians granted their first U.S. medical license.

For the fourth consecutive year, California led all states in the total number of licenses issued with 2560. New York was second with 1871; Pennsylvania was third with 936; and Ohio, fourth with 865. The fewest licenses were issued by Alaska (4) and Montana (9).

Unlimited licenses to practice medicine were issued to 1,012 osteopathic physicians throughout the country. Missouri with 240 osteopaths headed this list, trailed by 207 in Michigan, 98 in Kentucky and 93 in Ohio. New Jersey, in 1966, granted licenses to a total of 556 M.D.s and osteopaths.

Laser And Cancer

The National Cancer Institute, one of the National Institutes of Health, using laser equipment developed by the U.S. Army, is now doing research with high energy light beams to study their effects upon cancer. The term "laser" is derived from "light amplification by stimulated emission of radiation."

The laser instrument designed by the Army at Redstone Arsenal, Alabama, is undergoing modifications while being installed in a cancer research area at the National Institutes of Health, located at Bethesda, Maryland. The device was developed by the Army in response to a request from the National Cancer Institute following a study by the Missile Command's laser experts and Institute scientists. The earlier experimentation carried on at Redstone Arsenal involved exposure of both internal and external malignant growths in laboratory animals to pulses of infrared radiation from high energy lasers developed by the Missile Command. These experiments proved that the radiation could destroy some cancer cells under certain circumstances.

The National Cancer Institute proposes to use the laser instrument in a program of experimental work on laboratory animals. The results may indicate whether laser could be used for treatment of malignant tumors in humans. While many of the results thus far of laser irradiation upon tissue remain poorly understood, the experimental findings are sufficiently significant to justify further animal experimentations and refinements in laser instrumentation.

Dr. Kenneth M. Endicott is Director of the National Cancer Institute and Major General John G. Zierdt is Commanding General of the Missile Command. Dr. Alfred S. Ketcham, Chief, Surgery Branch, and Dr. Robert C. Hoye, surgeon, are the National Cancer Institute scientists in charge of the research, assisted by Mr. Grant Riggle, Biomedical Engineering and Instrumentation Branch, Division of Research Services, NIH, and Mr. William Hawkins, Electrical Engineer, Redstone Arsenal, Huntsville, Alabama. Mr. William B. McKnight and Mr. James R. Dearman, both engineers of the Army's Missile Command, designed the laser device.

MUST: The Army's Newest Medical Unit

The recent opening of the 45th Surgical Hospital at Tay Ninh, Viet Nam, brought a new concept in medical care to the battlefield. The 60-bed hospital, which may be expanded to 100 beds, was the first in Viet Nam to use MUST equipment. MUST consists of three basic elements. The expandable element is used as an operating room, supply center, or laboratory. An inflatable rubber shelter makes up the hospital ward element and the utility unit provides electrical power, air conditioning, heating, hot and cold running water, and waste water service. The elements of the MUST hospital are transportable by truck, helicopter, or cargo aircraft. They can be assembled in minutes, providing a controlled, contamination-free environment for optimum patient treatment regardless of the geographic area.

Other MUST elements include a Dental Clinic and Laboratory to blend modern engineering technology and dental research advances into self-contained equipment that is readily transportable. A Food Service System, consisting of main kitchen, ward food service area, dining hall, and sanitizing area is designed to accommodate over 500 patients and personnel. The pharmacy can operate on frigid arctic wastes or in steaming jungles, to store and dispense 400 different pharmaceuticals.

Nearly ten years of research went into the development of the new field anesthesia machine now in use at the 45th Surgical Hospital in Viet Nam. The portable X-ray processor provides rapid, on-the-spot development of dental X-rays. A new litter lifting device has been developed which can be lowered from a hovering helicopter where jungles, mountains, and other inaccessible areas preclude landing.

Teacher's Manual On Drug Abuse

The country's first comprehensive text to help teachers understand and combat the problem of drug abuse among students is now available. Entitled *Drug Abuse: Escape to Nowhere,* it is published by Smith, Kline and French Laboratories, in cooperation with the National Education Association, America's largest professional teachers organization. "The purpose of the book is to help teachers by filling the information vacuum about drug abuse," said M. Markoe Rivinus, President of Smith, Kline and French.

Dr. William G. Carr, executive secretary of NEA, called the guide "a timely and significant aid to educators in combating a serious threat to the youth of our nation. Young people need to understand the dangers of misusing drugs. They need informed and sympathetic adults who can help them. This book combines factual information with sensible suggestions for working with students at the elementary, high school, and college levels. I commend it to teachers, counselors, and administrators, as well as to parents."

Drug Abuse: Escape to Nowhere presents an historical look at drug abuse and has descriptions of products susceptible to abuse. The drug abuser is discussed, as are methods of therapy, educational approaches, problems of abuser identification, identification of drugs, what to do when drug abuse is suspected, and procedures for drug abuse prevention. Appendices cover drug distribution, legal controls, where to get help, films and references, and contain technical definitions, a glossary of slang, and a drug abuse reference chart.

"Facts and positive motivation are what young people need to help them make a sound decision should they one day face the pressure of 'going along' with the drug abuse crowd."

The 104-page illustrated text can be obtained from the National Education Association, 1201 Sixteenth Street, N.W., Washington, D.C. 20036, at $2.00 a copy.

A panel of experts from education, medicine, pharmacy, and law enforcement assisted in its preparation. Members were:

Harry J. Anslinger, former United States Commissioner of Narcotics and presently U.S. representative on the United Nations Commission on Narcotic Drugs.

Edward R. Bloomquist, M.D., Associate Clinical Professor of Surgery (Anesthesiology) at the University of Southern California School of Medicine.

Henry Brill, M.D., Vice Chairman of the New York State Narcotic Addiction Control Commission.

Michael N. Canlis, Sheriff and Coroner, San Joaquin County, California.

James Fox, Ph.D., Acting Chief, Center for the Study of Narcotic and Drug Abuse, National Institute of Mental Health, and Director of the Division of Drug Studies and Statistics, Bureau of Drug Abuse Control, Food and Drug Administration.

George P. Hager, Ph.D., Dean and Professor of Medicinal Chemistry, University of North Carolina School of Pharmacy.

Mrs. Jessie Kennedy, Principal of Northwestern High School, Detroit, Michigan.

John C. Krantz, Ph.D., Director of Scope, United States Pharmacopeia.

Edward Mileff, Ed.D., Consultant in Health and Safety Education for the American Association for Health, Physical Education, and Recreation of the National Education Association.

Ruth E. Neumann, Teacher of Health and Physical Education at White Bear Lake High School, Minnesota.

Einar A. Olsen, Ed.D., Professor and Chairman of the Department of Health Education, Mankato State College, Minnesota.

Did President Kennedy Have Addison's Disease?

It can be "strongly presumed" that President John F. Kennedy had Addison's Disease, says a pathologist in the July 10, 1967 *Journal of the American Medical Association.*

There were rumors—never publicly confirmed—that Mr. Kennedy suffered from the disease when he campaigned for and held the Presidency. The report of his autopsy did not mention such a finding. In a paper in this JAMA, Dr. John Nichols suggests that information about the health of a public official should be made public. He cited disclosure of the illness of President Eisenhower as a recent ex-

ample of such a policy. Details of the final illnesses of other Presidents who died or were assassinated while in office have been disclosed and extensively discussed in medical journals, Dr. Nichols said. However, President Kennedy suffered few, if any of the traditional symptoms of Addison's Disease, Dr. Nichols said. The President "was continuously engaged in strenuous mental and physical activity, tolerated extensive surgical trauma, and became father of four children, all without decrease in (his) life expectancy."

Dr. Nichols concluded that President Kennedy had the disease, after comparing newspaper reports of surgery undergone in 1954 by the then-Senator with an AMA medical-journal report of the same period. A report in the November, 1955, *Archives of Surgery*, discusses adrenocortical insufficiency during surgery, a familiar symptom of an Addison's Disease victim. One of the three cases reported was a "man, 37 years of age," who had had Addison's Disease for seven years. Dr. Nichols notes that this patient underwent spinal-fusion surgery at the Cornell University Medical College Complex, New York City, in October, 1954. The patient returned four months later for removal of a metal plate inserted during surgery. He then compares this report with *New York Times* stories of Senator Kennedy's surgery, performed on the same day at the same hospital. Senator Kennedy (age 37) returned four months later for removal of a metal plate, the Times reported on Feb. 26, 1955.

"These facts were independently documented by the two separate disciplines of medicine and journalism prior to (Kennedy's) candidacy for the Presidency," Dr. Nichols said. "It is most unlikely that two persons with the same age and clinical history of the late President would have undergone similar surgery in the same hospital on the same day and returned at exactly the same time four months later for removal of the plates."

The diagnosis of Addison's Disease could have been established at President Kennedy's autopsy, and perhaps the cause could have been determined, Dr. Nichols said. "However, the autopsy protocol is curiously silent on this point as well as on details of the pituitary, of his vertebral column, and sacro-iliac joints. "The silence on these points may be due to (a) accidental or intentional failure to search and observe, or (b) suppression of autopsy findings and existing clinical records by relatives or federal officials or both," Dr. Nichols said.

"The most unfortunate aspect is concealment of the diagnosis," Dr. Nichols said. "Addison's Disease, formerly fatal, is an honorable disease and is not a disease to be concealed. It has no stigma to be avoided. Patients with Addison's Disease can now be maintained under perfect control. . ."

It might be argued, Dr. Nichols said, that there would be a breach of the physician-patient relationship if the President's physicians made public comment on his illness without consent. This should not apply, however, if any other person, physician or layman, drew conclusions from previously published data, Dr. Nichols said.

Sports Physicians Warn Against Spearing

Physicians and sports officials have joined the American Medical Association in calling for an end to football "spearing." "Spearing" is the tactic in which a blocker or tackler uses his head as a battering ram. It's dangerous, both for himself and for the person he hits.

When polled by the American Medical Association's Committee on the Medical Aspects of Sports, the group was unanimous in warning against "spearing." The AMA committee asked for their comments when recent studies showed that head and neck injuries continue to constitute a very high percentage of serious injuries in football.

A tackler can inflict a tremendous amount of

punishment by driving his helmet into an opposing ball carrier. Moreover, he endangers himself, because his head and neck take the force of the blow. Serious injury and even death have resulted from brain and cord damage. In the correct, head-up tackle, the player uses his shoulders, arms, and chest to stop the ball carrier. In a "spear" he drives into his opponent with his head. By "spearing," the tackler may prevent the ball carrier from advancing a few extra inches — if he tackles him. With his head down, however, he not only risks serious injury, but is more likely to miss the tackle because he has a harder time seeing where he's going.

"Many neurosurgeons are appalled by coaches teaching the devastating 'spearing,' technic," said Richard C. Schneider, M.D., an Ann Arbor, Michigan neurosurgeon. Dr. Schneider pointed out that death may be only 30 seconds away if the blood vessels draining the brain are damaged by a heavy blow, or if hemorrhaging begins within the brain. In the neck, the spinal cord is an easy victim of bruising or cutting if neck vertebrae or cervical discs are forced out of place. This may result in death or permanent paralysis of arms and legs and loss of bladder and bowel control. Thirty such cases were reported during the football seasons of 1959 through 1964, he said.

Football has a good safety record, considering that a million players are involved each fall. It could be even better, if head and neck injuries could be reduced. In 1966, head and neck injuries were responsible for 23 of the 24 fatalities directly attributed to injuries in college and high school football. "Strict enforcement by officials of the rule against 'spearing' is important," said Donald B. Slocum, M.D., orthopedic consultant to the University of Oregon football team. "While every infraction may not be discernible, those that are should be rigorously penalized — particularly those that occur on second impact when a runner already has been tackled," Dr. Slocum said.

Said Clifford B. Fagan, executive secretary of the National Federation of State High School Athletic Associations: "There is no place in interscholastic football for 'spearing.' Responsible athletic administrators and football leaders everywhere deplore the fact that a small number of coaches teach it. The high rate of serious injury which results from 'spearing' makes it self-evident that the teaching of it must not be tolerated.

Elimination of 'spearing' "would certainly cut down the number of fatalities in football," said L. W. Combs, M.D., director of the student health center, Purdue University. "It has been disappointing for me to realize that some high school coaches are teaching 'spearing' as a sound football practice," Dr. Combs said. "At the college level, we are very much aware that this makes the player more vulnerable to injuries of the head and neck. The headgear has been highly developed by equipment manufacturers with the advice of physicians, trainers, and others as a protective gear. It is entirely unfitting, however, that some coaches persist in teaching its use as an offensive and defensive weapon." Since the introduction of the hard helmet and face piece, coaches have felt that the head and face are adequately protected. This, however, affords no protection at all for the neck which is subjected to injury through this repeated 'butting' technic.

Said Murray Warmath, football coach at the University of Minnesota, " 'Spearing' will never disappear from the game until we quit coaching it and until we absolutely disallow its use on the part of our men." "It isn't the first man who makes the tackles," Warmath said, "it's that second tackler. He puts his head down, closes his eyes, and piles into the man who's down with one intent, and that's to maim and cripple."

Since 1960, most of the football deaths resulting directly from football participation have been caused by head and neck injuries. The AMA Committee on the Medical Aspects of Sports called on all team physicians to discourage 'spearing,' urged coaches to teach against the tactic, and warned players of the dangers of the practice.

Medicine Still Top Career Choice

The study of medicine ranks as the top career choice among 1967 National Merit Scholarship Program semi-finalists, the scholastic elite among the nation's graduating high school seniors. Of the semi-finalists who already have decided upon their career choices, 8 per cent plan to become physicians, according to an AMA tabulation of career choices indicated in the program list of 14,000 semi-finalists published by the National Merit Scholarship Corporation, administrator of the Merit Program.

The compilation revealed that 159 more of the current semi-finalists selected medicine than had their counterparts in the 1966 program. This represented a gain of 20 per cent.

Sharp increases also were noted in the number of semi-finalists planning to study for careers in the life sciences and physics and chemistry. Of those semi-finalists already decided upon their career choices, 27 per cent plan to enter medicine or one of these scientific fields. One of every three of all semi-finalists indicated he had chosen one of these careers or another allied to medicine. The number of aspiring physicists jumped from 506 to 681, a 34 per cent rise; chemists from 288 to 480, a 50 per cent gain; biologic scientists from 144 to 237, a 65 per cent escalation. Percentage-wise, the sharpest gain — 100 per cent — was noted for biophysicists which increased from 13 to 26.

Other significant gains in career fields selected were registered in psychology where the number of candidates climbed from 136 to 233, a 71 per cent increase; in verterinary medicine, where a 71 per cent gain from 42 to 72 was indicated; and in pharmacy, where a 50 per cent gain from 26 to 38 students occurred over last year.

National Merit Scholarship Program semi-finalists are selected from the upper one per cent of the nation's graduating seniors on the basis of qualifying tests conducted at approximately 17,500 secondary schools.

202nd ANNUAL MEETING
THE MEDICAL SOCIETY OF NEW JERSEY

May 18-22, 1968

Haddon Hall, Atlantic City

Program Outline

Friday, May 17, 1968

4:00 p.m. — Board of Trustees
7:00 p.m. — Cocktails and Buffet-Dinner

Saturday, May 18, 1968

All Day — Installation of Exhibits
10:00 a.m. — Registration Opens
1:00 p.m. — Golden Merit Award Ceremony followed by Reception for GMA Recipients and their families
3:00 p.m. — House of Delegates and President's Farewell Address
4:30 p.m. — Nominating Committee
7:00 p.m. — Officers' Dinner

Sunday, May 19, 1968

9:00 a.m. — Registration Opens
9:30 a.m. — Special Scientific Sessions
10:00 a.m. — Coffee-meeting with Reference Committee Chairmen
10:45 a.m. — Reference Committees
12:00 noon — Exhibits Open
3:15 p.m. — House of Delegates (election)
4:00 p.m. — Inauguration of Incoming President followed by General Session
6:00 p.m. — Inaugural Reception
8:00 p.m. — Inaugural Dinner

Monday, May 20, 1968

9:00 a.m. — Registration and Exhibits Open
All Day — Scientific Sessions (MSNJ)
7:00 p.m. — Annual Dinner-Dance

Tuesday, May 21, 1968

9:00 a.m. — Registration and Exhibits Open
9:30 a.m. — House of Delegates
2:00 p.m. — Scientific Sessions (MSNJ)
7:00 p.m. — Exhibitors' Reception-Buffet Dinner

Wednesday, May 22, 1968

9:00 a.m. — Registration and Exhibits Open
9:00 a.m. — Board of Trustees
9:30 a.m. — Scientific Sessions (MSNJ/Special)
12:00 noon — Exhibits and Convention Close

ANNOUNCEMENTS

Air Pollution Institute

An institute on air pollution control will be held at the Pollak Hospital, 100 Clifton Place, Jersey City, on November 27, 28, and 29, 1967. Sponsors are: The Air Pollution Control Commission and Municipal Health Officers of Hudson County, the County Medical Society, the New Jersey Chapter of the American College of Chest Physicians, and the Pollak Hospital. The institute is supported in part by a grant from the Ciba Pharmaceutical Company.

You, as a reader of this JOURNAL, are invited to any or all of the sessions. Want more details? Write to the Medical Director, Pollak Hospital, 100 Clifton Place, Jersey City 07304.

Seminar On Disability Determinations

On Wednesday, November 29, 1967, starting at 9 a.m. (under the sponsorship of the New Jersey Rehabilitation Commission, Disability Determinations Service) there will be a one day seminar entitled, "The Doctor and the Disability Decision." The meeting will be held at the Rutger's Labor Education Center, Ryders Lane, New Brunswick.

Physicians will have an opportunity to learn disability evaluations, including their own role in these decisions. Special attention will be given to disabilities in the fields of orthopedics, cardio-pulmonary diseases, psychiatric disorders, special senses, and neurologic conditions. Doctors having special problems with disability determinations may submit questions in advance to Jarvis M. Smith, M.D., Medical Director, New Jersey Rehabilitation Commission, Labor and Industry Building, Trenton, 08625; these questions will be discussed at the meeting.

Problems In Endocrine Pathology

The perennial and popular slide seminar of the New Jersey Society of Pathologists will be held this year on Saturday, December 2nd. The moderator will be Dr. Sheldon Sommers of Columbia University, College of Physicians and Surgeons, and the theme will be, "Problems in Endocrine Pathology." This is supported by the State Department of Health. For further information write to the Public Relations Office, New Jersey State Department of Health, Health and Agriculture Building, John Fitch Plaza, Trenton, New Jersey 08625.

Send Your Old Journals Abroad

Instead of throwing old medical journals away, please send them where they will be really appreciated — to physicians everywhere in the world who are short of current medical literature. The way to do this is to write to the Director of the Doctor-to-Doctor Program of the World Medical Association (10 Columbus Circle, New York 10019) and indicate what medical journals you have available for discard. Dr. Ada Chree Reid, Director of this program, will then give you names and addresses of English-reading physicians who would appreciate your old copies.

Emergency Call Number For State Health Department

Put this number near your phone: (609) 392-2020.

That is the "after hours" emergency number for our State Health Department. Use it on holidays, Saturdays, Sundays, and after 5 p.m. on other days. The answering service will then route your call to the physician, veterinarian, sanitarian, or technician on call for your particular problem.

(609) 392-2020

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1967

November

14 **Bergen County Medical Society**

14 **New Jersey Dermatological Society**
Newark Beth Israel Hospital
Clinical Meeting

15 **New Jersey State Dental Society**
Semi-Annual Session

15 **Monmouth County Medical Society**
Monmouth Medical Center,
Long Branch
Medico — Legal Symposium

15 **Middlesex County Medical Society**

15 **6th Annual Obstetrical and Gynecological Seminar**
St. Peter's General Hospital
New Brunswick

15 **New Jersey Academy of Ophthalmology and Otolaryngology**
Robert Treat Hotel, Newark

16 **The Academy of Medicine of New Jersey and Morris County Medical Society**
Warner-Lambert, Morris Plains
Symposium — "Oral Contraceptives"

16 **Gloucester County Medical Society**

21 **Passaic County Medical Society**

22 **Monmouth County Medical Society**

22 **The Academy of Medicine of New Jersey**
Newark City Hospital
Workshop in Cytogenetics and Inborn Errors of Metabolism

28 **Cape May County Medical Society**

29 **New Jersey Rehabilitation Commission, Disability Determinations Service**
Rutgers Labor Education Center
Ryders Lane, New Brunswick
Seminar — "The Doctor and the Disability Decision"

29 **The Academy of Medicine of New Jersey**
Princeton Hospital, Princeton
Symposium on Congestive Heart Failure

December

2 **New Jersey Chapter, American College of Surgeons**
St. Barnabas Hospital, Livingston
Annual Meeting

2 **New Jersey Society of Pathologists**
Nassau Inn, Princeton
Seminar—"Problems in Endocrine Pathology"

5 **Hudson County Medical Society**
"Health is Everybody's Business"

6 **The Academy of Medicine of New Jersey**
Robert Treat Hotel, Newark
"Antibiotic Induced Toxic and Hypersensitivity Reactions"

6-7 **The Academy of Medicine of New Jersey**
Newark City Hospital
Workshop on Culdoscopy

12 **Bergen County Medical Society**

12 **Cumberland County Medical Society**

13 **Gloucester County Tuberculosis and Health Association**

13 **Ocean County Medical Society**

13 **The Academy of Medicine of New Jersey**

Cherry Hill Inn
Symposium on Trauma

14 **Burlington County Medical Society**
Scientific/Business

20 **Middlesex County Medical Society**

21 **Morris County Medical Society**

21 **Gloucester County Medical Society**

1968
January

2 **Hudson County Medical Society**
"The Problem of Persistent Viral Hepatitis"

9 **Bergen County Medical Society**

10 **Camden County Medical Society**
"Current Medical Research with Immediate Clinical Significance"

10 **Gloucester County Tuberculosis and Health Association**

11 **Essex County Medical Society**

17 **The Academy of Medicine of New Jersey**
Morristown Memorial Hospital
Symposium — "Acute and Chronic Care of the Alcoholic"

18 **Morris County Medical Society**

18 **Gloucester County Medical Society**

21 **American Academy of General Practice**
Holiday Inn, Newark
Symposium — "Respiratory Diseases"

24 **Saint Elizabeth Hospital**
Elizabeth
"Family Life"

30 **Cape May County Medical Society**

31 **Essex County Heart Association and Academy of Medicine**
Mutual Benefit Life Insurance Company, Newark
"Operable Heart Disease"

February

6 **Hudson County Medical Society**
"Models of the Heart in Electrocardiography"

13 **Bergen County Medical Society**

14 **Gloucester County Tuberculosis and Health Association**

15 **Morris County Medical Society**

15 **Gloucester County Medical Society**

21 **The Academy of Medicine of New Jersey**
Robert Treat Hotel, Newark
Pediatric Symposium

28 **The Academy of Medicine of New Jersey**
Princeton Hospital, Princeton
Symposium — "Problems of Oral Contraceptives"

March

6 **Camden County Medical Society**
Ladies night — "Family Life Education"

6-9 **New Jersey Academy of General Practice**
Atlantic City

7 **Hudson County Medical Society**
"Current Trends in Medical Malpractice Litigation"

7-8 **The Academy of Medicine of New Jersey**
Newark City Hospital
Workshop on Culdoscopy

12 **Bergen County Medical Society**

12 **Essex County Medical Society**
Hotel Suburban, East Orange
"What Can An Office Consultant Do For You?"

13 **Gloucester County Tuberculosis and Health Association**

13 **The Academy of Medicine of New Jersey**
Mountainside Hospital, Montclair
Symposium on Supraventricular Arrhythmias

19 **Passaic County Heart Association**
Annual Meyer Notkin Lecture

21 **Morris County Medical Society**

26 **Cape May County Medical Society**

27 **New Jersey Heart Association**

April

2 **Hudson County Medical Society**
"Some Psychiatric Problems of Childhood and Adolescence"

9 **Bergen County Medical Society**

10 **Gloucester County Tuberculosis and Health Association**

18 **Morris County Medical Society**

18 **Gloucester County Medical Society**

24 **The Academy of Medicine of New Jersey**
Veterans' Administration Hospital
East Orange
Dental Symposium — "Periodontal Disease-Etiology and Treatment"

May

1 **Camden County Medical Society**

1 **Passaic County Heart Association**
Symposium on New Concepts in Cardio-Vascular Disease

7 **Hudson County Medical Society**
Election of Officers

8 **Gloucester County Tuberculosis and Health Association**

9 **Essex County Medical Society**

14 **Bergen County Medical Society**

16 **Morris County Medical Society**

16 **Gloucester County Medical Society**

18-22 **The Medical Society of New Jersey**
Haddon Hall, Atlantic City
Annual Meeting

OBITUARIES

Dr. John G. Decker

Dr. John G. Decker, one of Bergen County's senior otolaryngologists, died on September 24, 1967. Born in Wisconsin in 1902, he received his M.D. degree at the University of Minnesota in 1929. At the conclusion of internship, he came east, and in 1930 opened an office for the general practice of medicine in Hasbrouck Heights. He became increasingly interested in otolaryngology and served on that specialty staff at both Hackensack and Valley Hospitals. He was active in the affairs of our Bergen County Medical Society and in the American Academy of General Practice.

Dr. Sloan G. Stewart

Atlantic County lost one of its medical leaders on September 18, 1967, with the death that day of Sloan G. Stewart. Born in 1901, he received his baccalaureate degree from Princeton in 1923, and his M.D. from Johns Hopkins in 1927. He then won one of the coveted Johns Hopkins Hospital internships. Following this service, he became a resident in internal medicine at the hospital of the University of Pennsylvania. On concluding his residency in 1931, he became an instructor in medicine at the University of Pennsylvania. Two years later, he came to Atlantic City to enter private practice. He then limited himself to internal medicine and became a Fellow of the American College of Physicians. In 1942 he was commissioned in the Army, rising from lieutenant to full colonel, soon becoming medical director of the McCloskey General Hospital. He returned to practice in Atlantic City, becoming active in the professional and administrative affairs of the Atlantic City Hospital, eventually becoming president of that institution.

BOOK REVIEWS

The Neuroses. Henry P. Laughlin, M.D. Washington, D.C., 1967, Butterworths. Pp. 1076 (Price not stated)

In this king-sized volume, Laughlin seeks to cover nearly all aspects of the dynamics, diagnosis, and treatment of the psychoneuroses. Each clinical entity is presented first historically, then in terms of formulation and development, and finally with respect to treatment. In addition to the traditional topics in this field, the author touches on such less usual ones as drives toward a security-giving or solacing object, technics of brain-washing, emotional disorders following head injury, and military reactions. Laughlin likes to use less familiar terms now and then — some of them, indeed his own neologisms. So one's reading is occasionally punctuated by such outre words as hygeiaphrontic, endogain, and soteria. Throughout the text are descriptions of psychotherapy, which Laughlin sees as the backbone of treatment; electric shock (about which he restrains his enthusiasm); and medication, on which he offers a well-balanced view. The usefulness of the book is enhanced by some excellent tabulations and outlines, by rich and interesting historical material, by a sprinkling of quizzes which enables the reader to measure his own progess, by an almost unique lexicon of psychiatric concepts, and by some 200 compact and illustrative case reports.

The book is beamed primarily at mental health professionals including the psychiatric resident, and at those general physicians who want to know more about psychiatry than the usual pious generalizations. And many experienced psychiatrists will get fresh formulations from it, too. HENRY A. DAVIDSON, M.D.

Infant Nutrition. Samuel J. Fomon, M. D. Philadelphia, 1967, Saunders. Pp. 299. Illustrated. ($10.50)

This book encompasses may aspects of infant nutrition. Written primarily for pediatricians and general practitioners, it would be of great value also to nutritionists, dieticians, and biochemists. The text presents up-to-date information on nutritional needs of infants beginning with needs of protein, fats, carbohydrates, vitamins, minerals, and water. A rational approach (and plea) to vitamin supplementation is presented with caution. We are advised to avoid iatrogenic or accidental hypervitaminoses in place of the avitaminoses as occurred in the past. Information on Vitamin E, fluoride supplementation, iron metabolism, and radioactive contaminants is especially interesting.

Emphasis is given to infant nutrition and renal solute load both in health and disease. Touched upon but still unsettled is the subject of proper dietary saturated and unsaturated fatty acids in reducing infant serum liquid content.

The author further puts in proper perspective the choice of certain formulas in health and disease. From the obvious use of soy milks in infantile eczema or Lanolac in early congestive heart failure to the more uncommon states where we would use Lofenalac in phenylketonuria, Nutramigen in galactosemia, or again, Nutramigen in Lactase deficiency states.

The book has numerous charts and graphs concerned with such subjects as carbohydrate content of infant foods, iron contents of commercial foods, and the composition of various milks. Two appendices are presented, one concerned with the composition of infant foods, and the other technics for metabolic studies. Although the literature dealing with infant nutrition is vast, the tables, charts, and bibliography alone in this book would improve our approach and enhance our understanding of the subject.

FRANK C. VANORE, M.D.

Endocrinology of the Testis (Ciba Foundation Colloquia). Edited by G. E. W. Wolstenholme and Maeve O'Connor. Boston, 1967, Little, Brown and Company. Pp. 331. Illustrated. ($12.50)

The sixteenth, and final, volume of the Ciba Foundation colloquia on endocrinology is a noteworthy contribution to our understanding of the endocrinology of the testis. Dedicated to Dr. Warren O. Nelson, it includes contributions by 26 authors. Many of the subjects are extensions of Dr. Nelson's pioneering work.

While the text is heavily weighted toward the disciplines of the endocrinologist and the biochemist, the clinician interested in infertility and gonadal disorders can benefit from many of the chapters. There are articles on spermatogenic and androgenic function evaluated by testis biopsy. In addition, the role of testostcrone on spermatogenic function, and the amount of estrogen production by the testis are analyzed. The failure of normal spermatogenesis in the absence of the pituitary, even with supplementation with all of our presently available hormones, is of great interest to all that are dissatisfied with our current therapy for subfertile patients.

Some sections are difficult to read. On the whole, however this is an important reference book, including a compilation of facts on the androgenic and spermatogenic functions of the testis. The Ciba Foundation again has given us an unparalleled exposure to the outstanding investigators and their latest works in a rapidly-changing field. ROBERT H. STACKPOLE, M.D.

Pathologic Physiology: Mechanisms of Disease. 4th Edition. William A. Sodeman, M.D. and William A. Sodeman, Jr., M.D. Philadelphia, 1967, Saunders. Pp. 1051. Illustrated ($19.00)

This book tries to explain what physiologic mechanisms have been deranged by what diseases. It thus aspires to provide a more rational approach to diagnosis and therapy. It is not a substitute for a classical textbook of medicine and would be best used as a supplement to such a text. Thirty authors have collaborated to produce the book and, as a result, there is some degree of repitition and unevenness in presentation. For example, the figure on page 387 is virtually the same as the one on page 458. More space is devoted to belching than to cardiomyopathies.

However, the book does fulfill its intent. It is of greatest interest to specialists in internal medicine who practice in an academic setting. Scattered throughout the volume are numerous tables which will be helpful to those using the book as a reference. For example, one table lists over fifty causes of hypertension and another, thirty six causes of malabsorption!

RAYMOND SCHIFFMAN, M.D.

Modern Treatment: Kidney Stones, Felix O. Kelb, M.D., editor; **Acute Oral Ulcerations,** Edward A. Graykowski, M.D., D.D.S., editor. New York, 1967, Hoeber Medical Division, Harper and Row. Pp. 129. ($18 per year by subscription)

Here is another in the bi-monthly publication series, "Modern Treatment." The first half covers a symposium on the diagnosis and treatment of kidney stones. Each chapter ends with a good list of up-to-date references. Appendices cover chemical tests for stones, and lists of diets.

The second section covers the diagnosis and treatment of oral ulcerations, specifically (and briefly) of herpes and generalized stomatitis.

These publications serve a limited purpose and are short-lived. They probably will not retain a permanent place of reference in the practitioner's library.

HARRY M. POPPICK, M.D.

Development of the Lung (Ciba Foundation Symposium). Edited by A.V.S. DeReuck and Ruth Porter. Boston, 1967, Little, Brown. Pp. 408. Illustrated. ($13)

This is a transcription of a multidisciplinary symposium held in 1965. It is a valuable contribution to understanding the structure and function of the lung with major sections on phylogeny, ontogeny, the gas/liquid interface, intrauterine gas exchange and the start of breathing. The colloquium derives extra valve from the diverse backgrounds of the participants from zoology, physiology, chemistry, pathology, and pediatrics applying their research knowledge to one subject; from the frank and sometimes heated discussion and criticism of each paper; and from new concepts which emerge with respect to lung development.

Of special interest is the newly recognized fact that cutaneous respiration of the amphibians was not merely a specialization but was important in the evolutionary line. There is emphasis of the fact there is collateral alveolar ventilation, which is less in the upper lobes due to a smaller number of segments, as is the blood flow to this region. This tends to confirm the impression of these lobes being more susceptible to disease as in reinfection tuberculosis. Ross, speaking on lungs and the placenta, states that there is little difference between these systems if a distinction is made between the villous blood flow where exchange takes place and the intervillous blood flow which is shunted from the fetal circulation. The book includes a well conceived diagram which helps in understanding the complex problem of the initiation of respiration in the newborn.

Due to its basic design, this is not an easy book to read. It leaves several questions unanswered such as, the basic role of mucus in the bronchial tree and the understanding of the production, function, and clinical importance of pulmonary surfactant. It underlines the unresolved morphologic problems of the lung due to the inherent difficulty of studying structure and function in post-mortem or laboratory fixed specimens. As a whole, however, this work is important to those involved in pulmonary medicine or research. It correlates basic research with clinical problems. It is a reference to the special subject matter. Except for the philosophical value of the material on phylogeny of the lung, this text is not recommended for the casual reader.

JAMES R. WIANT, M.D.

Evaluation of the Dangerousness of the Mentally Ill. Edited by J. A. Rappeport, M.D. Springfield, Illinois, 1967, Charles C. Thomas. Pp. 118 (Price not stated)

At its 1965 convention, the American Psychiatric Association had a section on evaluation of the dangerousness of the mentally ill. This small book is a record of that meeting. The hope was to develop some criteria for deciding whether a psychotic or antisocial patient was likely to commit a crime of violence. With varying degrees of tentativeness, a number of clues were suggested — such as a history of suppressed aggressive drives, of cruelty to animals, of previous bouts of violence or of fire-setting. Most of the speakers insisted that the violence-record of mental patients was better than that of the population at large. The editor, however, gave different figures which suggested that when patients were hospitalized because of violent behavior, their post-hospital record was likely to be worse than that of the general population who had never been in a mental hospital. Also discussed is the role of medication with psychotropic drugs. It was the consensus that these drugs often did control potentially violent behavior; but that a discontinuance of the drug (because, perhaps, the outpatient couldn't afford the cost) might lead to explosive violence, much as withdrawal of tranquilizers sometimes leads to convulsions. The book raises many throught-provoking questions even if it doesn't provide any pat answers.

ABRAHAM LEFF, M.D.

Handbook of Physical Therapy. Robert Shestack. New York, 1967, Spring Publishing Company. Pp. 212. ($4)

For the many physicians lacking in basic knowledge of the concepts of physical therapy, here is a brief introduction to the methods of physical medicine. The first section of the book is concerned with a description of modalities of physical therapy, including methods of applying heat, such as infra-red, diathermy, ultrasonics, ultraviolet and various types of currents. Also, discussed are hydrotherapy, massage and types of exercises. The second section reviews specific pathologic entities, such as arthritis and rheumatic disorders, peripheral nerve problems, vascular conditions, central nervous system disorders and a wide variety of other conditions. This handbook might prove useful to a number of physicians in defining the types of therapy available and in showing how they might be used in a particular patient. It must be noted, however, that the text is entirely uncritical both in listing the supposed effects of the various modalities and in recommending their use. The author, for instance, in discussing arthritis states "massage should be started as soon as the acute inflammatory process has subsided." Dr. Charles Ragan, on the other hand, has stated "we are not convinced that . . . diathermy, ultrasonics, whirlpool bath or massage have a place in the management of rheumatoid arthritis." This is the problem with Mr. Shestack's book. He recommends some form of physical therapy for almost any condition, varying from ultraviolet light for alopecia areata to diathermy for laryngitis. Some of his statements are probably inaccurate. I am not sure that ultraviolet radiation can be relied upon to improve the elasticity of the skin or elevate muscular tone. Physical therapy has definite uses but they are sometimes obscured by expensive, impressive-looking pieces of equipment. With this caveat in mind, physicians might find this inexpensive soft-covered book of some value.

LONNIE B. HANAUER, M.D.



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cautions: Since varying degrees of urinary hesitancy may occur in elderly males with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

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Dosage: The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

(1) Bilbao, M. K.; Frische, L. H.; Rösch, J., and Dotter, C. T.: Hypotonic Duodenography, Scientific Exhibit, Radiological Society of North America, Chicago, Nov. 27–Dec. 2, 1966.

(2) Bilbao, M. K.; Frische, L. H.; Dotter, C. T., and Rösch, J.: Hypotonic Duodenography, Radiology, in press.

SEARLE

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For complete details,
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Preludin is indicated only as an anorectic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension, or pregnancy. For use in pregnancy, see Warning.

Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets® prolonged-action tablet a day, taken by midmorning.
Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.

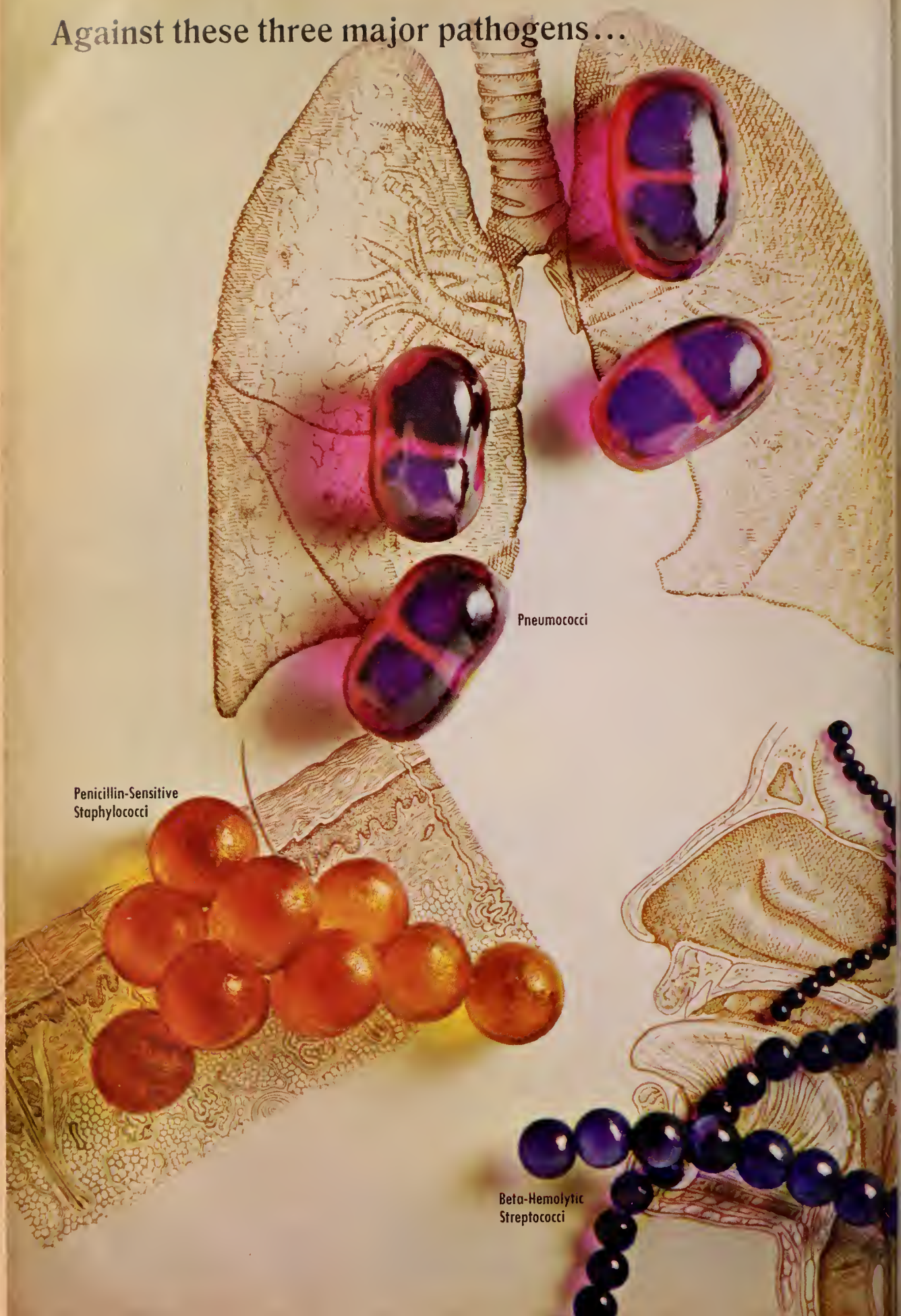


Warning: Do not use during first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.
Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations, or delusions. Do not exceed recommended dosage.
Side Effects: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache. (B)R46-560-A

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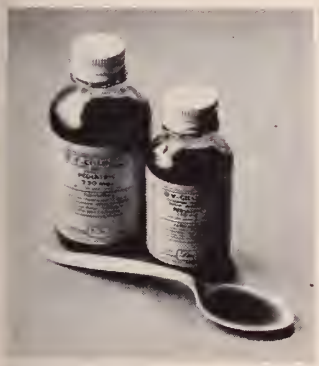
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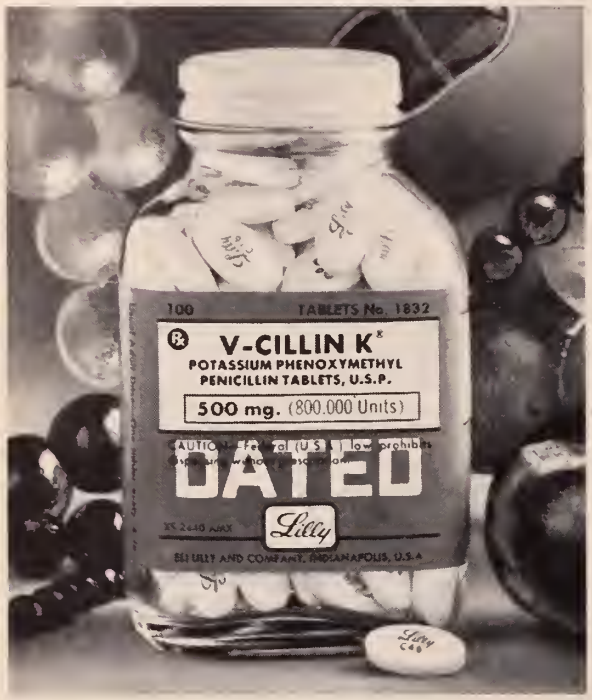
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New 500 mg. tablets...a more convenient way to give high doses



Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

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Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombacytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

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Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

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DESBUTAL 15 Gradumet

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FRONT SIDE

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The Gradumet is made up of thousands of interconnecting channels, much like a sponge. These channels—filled with a drug—end at the outer surface of the tablet. When fluid comes in contact with the Gradumet, the drug in the outer ends of the channels dissolves. As the fluid makes its way up the channels, there is a continuous release of medication.

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See Brief Summary on next page.

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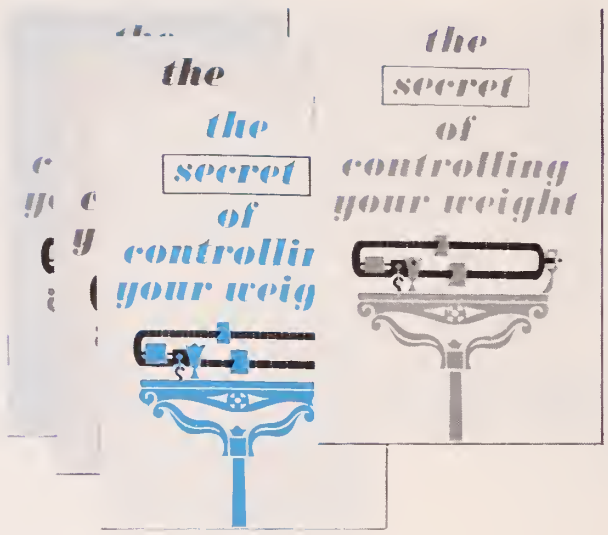
ECONOMY

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
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PRECAUTIONS, SIDE EFFECTS: Observe cau tion in patients with hypertension, cardiovascula disease, hyperthyroidism, old age, or those sensitiv to sympathomimetic drugs. Prolonged usage ma lead to tolerance or psychic dependence. Carefu supervision is necessary to avoid chronic intoxica tion and addiction.

Amphetamine side effects such as a headache, ex citement, agitation, palpitation or cardiac arrhythmi usually may be controlled by reducing the dose Paradoxically-induced depression is an indicatio to withdraw the drug. Pentobarbital (in Desbutal may cause skin rash. Nervousness or excessive sedation with Desbutal is usually transient.

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Dosage: 50-200 mg. (¾-3 grains) at bedtime.

[031767]

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Pectin (2½ grains) 162 mg.
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(alcohol 0.69%)
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MSNJ Scientific Exhibits

Members of The Medical Society of New Jersey are invited to participate in the Scientific Exhibits at the 202nd Annual Meeting, May 18 to 22, 1968, Haddon Hall, Atlantic City. Exhibits will open at noon on Sunday, May 19, and close at noon on Wednesday, May 22. The hours on Monday and Tuesday will be from 9 a.m. to 5 p.m. Applications may be obtained from the Executive Offices in Trenton, Mrs. Marion Walton, Convention Manager.

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Poliovirus Vaccine Live, Oral, Trivalent

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CONTRAINDICATIONS and PRECAUTIONS: Do not inject this vaccine. Postpone vaccination in those with acute illness; in any condition having an adverse effect on the immune response mechanism (leukemias, lymphogenous diseases, dysgammaglobulinemias, during treatment with immune serum globulins or with cancer chemotherapy agents, etc.); in advanced debilitated states; or if there is persistent vomiting or diarrhea, or clinical signs of virus (including enterovirus) infection. Live measles and oral poliovirus vaccines should probably be given separately.

SIDE EFFECTS of significance have not been reported. However, the risk of vaccine-induced poliomyelitis, estimated to be from 1:2,500,000 to 1:50,000,000 should be considered.

Supplied in trays of 10. Order through your Lederle Representative or regular source of supply.

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Synirin®

ACETYLSALICYLIC ACID (ASPIRIN)..... 5 GR.
*PENTOBARBITAL (ACID)..... 1/8 GR.
*Warning: may be habit-forming

Synirin provides prompt barbiturate potentiation of aspirin without limiting the therapeutic usage of aspirin. Both pentobarbital and aspirin begin their action together promptly and last 4 or 5 hours. There is no accumulation.

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SYNIRIN is another pharmaceutical achievement

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

Butazolidin®, phenylbutazone
In Acute Superficial Thrombophlebitis

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make regular blood counts. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Purpuric rash has also been reported. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Acute Superficial Thrombophlebitis: Initial: 6 capsules or tablets daily in divided doses for 2 or 3 days. Maintenance: 3 capsules or tablets daily. Usual duration of therapy is 5 to 7 days (rarely beyond 10 days). 6509-V(B)R2

*Stein, I.D.: Presented at the American Academy of General Practice, Dallas, Sept. 1967.

For complete details, please see full prescribing information.

it used to take weeks



Acute superficial thrombophlebitis before treatment



After 5 days of Butazolidin therapy

In acute superficial thrombophlebitis, patients were usually bedfast for 2 to 4 weeks, tying up hospital beds, requiring costly nursing care and time-consuming procedures such as warm soaks and packs.

When Butazolidin was added to the usual regimen, 960 of 1000 patients obtained complete resolution; most required only 30 capsules or tablets; relief of pain and discomfort and regression of inflammatory signs and fever occurred within a few days.*

Side effects occurred in 6% of the 1000 patients. While none were serious or long-lasting, Butazolidin can produce severe side effects in rare instances. Further, not every patient can take Butazolidin. Therefore, select patients with care and follow them closely. Contraindications, Warning, Precautions and Adverse Reactions are summarized in adjacent column.

Butazolidin gets bedfast thrombophlebitics out of bed, fast. Usual duration of treatment is 5 to 7 days, and rarely exceeds 10 days. Try it and see. For full details, please refer to the complete prescribing information.

Butazolidin® alka

Capsules:
phenylbutazone, 100 mg.; dried aluminum hydroxide gel, 100 mg.; magnesium trisilicate, 150 mg.; homatropine methylbromide, 1.25 mg.

Butazolidin®

phenylbutazone

Tablets of 100 mg.

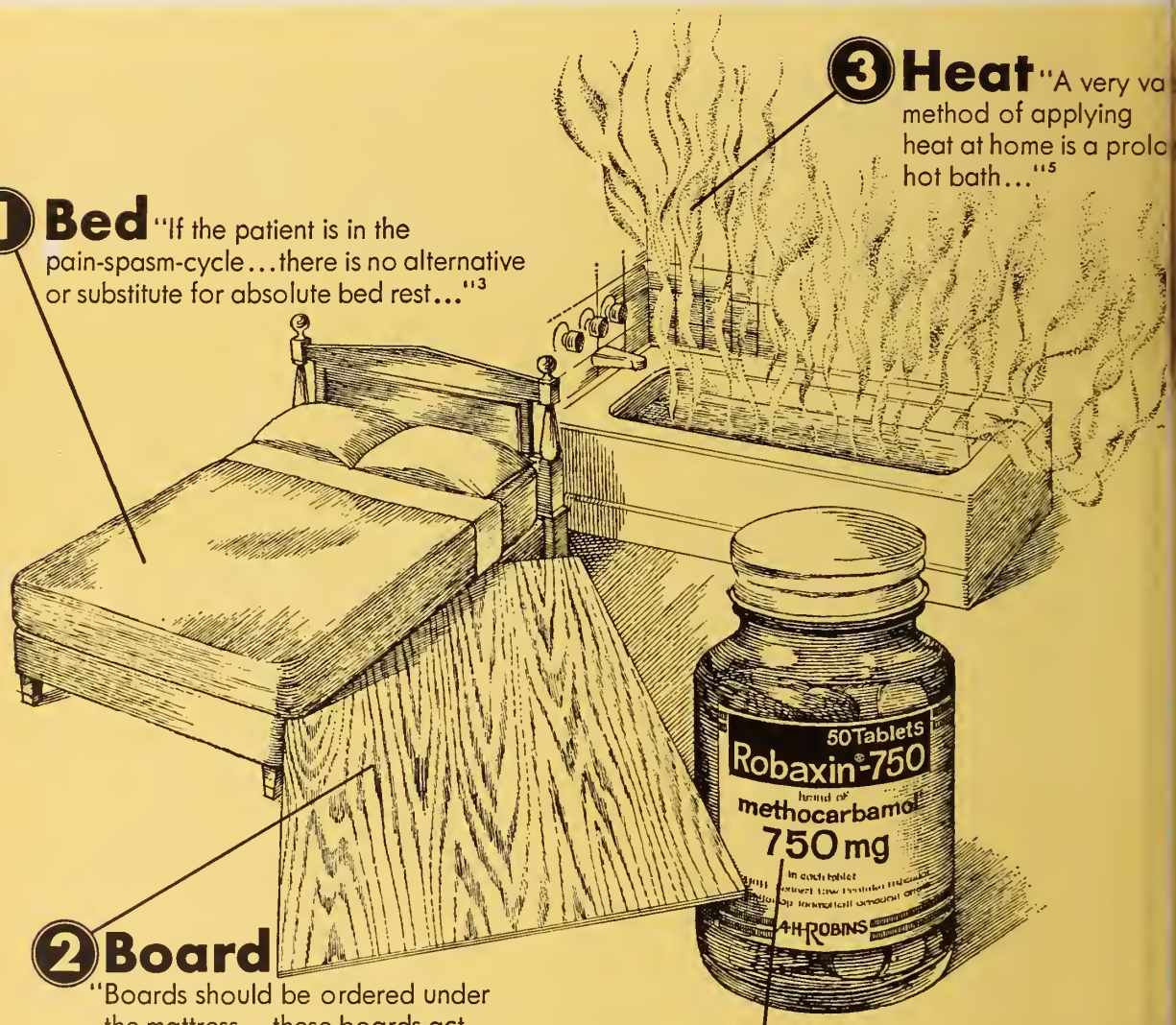
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LOW-BACK PAIN

A CONSERVATIVE, FOUR-POINT PROGRAM

The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.[1,2] For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:



1 Bed "If the patient is in the pain-spasm-cycle...there is no alternative or substitute for absolute bed rest..."[3]

2 Board "Boards should be ordered under the mattress...these boards act by immobilizing the spine..."[4]

3 Heat "A very va... method of applying heat at home is a prolo... hot bath..."[5]

4 Robaxin®-750 (methocarbamol, 750 mg. caps... shaped tablets) A well-tolerated skeletal muscle relaxant, metho... bamol helps relieve spasm "...without interfering with norr... tone and movement."[7] And ther... is little likelihood of sedation.[6]

Indicated for relief of skeletol muscle sposm. **Contraindicated in** hypersensitive potients. **Side Effects** (lightheadedness, dizziness, drowsiness, nousea) moy occur rorely, but usually disappear on reduced dosage. Hypersensitivity reoctions develop infrequently. See product literoture for further detoils. **Also available:** Roboxin® Tablets (methocorbamol, 500 mg.) Roboxin Injectable (methocorbomol, 1 Gm./10 cc.)

References: (1). Godfrey, C.M.: Applied Therop. 8:950, 1966. (2). Gottscholk, L.A.: GP 33:91, 1966. (3). Rowe, M.L.: J. Occup. Med. 2:219, 1960. (4). Cozen, L.: South Dakoto J. Med. 18:26, 1965. (5). Soto-Holl, R.: Med. Sc. 14:23, 1963. (6). Weiss, M. ond Weiss, S.: J. Am. Osteopath. A. 62:142, 1962. (7). Feuer, S.G., *et al.*: New York J. Med. 62:1985, 1962.

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A Building Block approach to treating hypertension

With these three therapeutic building blocks you can create a once-a-day regimen to fit almost any degree of hypertension. See the following pages for details . . .



Consider starting your hypertensives on this basic thiazide

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A single daily dose of Enduron provides sodium excretion around the clock

Enduron is a true 24-hour single-dose thiazide. Its sodium excretion is not squeezed into an abrupt peak during the first several hours. It is well-sustained in a plateau-like effect—with little reduction for the first 12 hours, and decline thereafter only gradual.

Potassium loss, by contrast, is low. It reaches an early minor peak, then subsides rapidly. Moreover, since dosage is but once a day, there is but one daily peak of potassium loss. As with all thiazides, however, dietary potassium supplementation should also be considered, especially in long or intensive therapy.

Use Enduron as an ideal starting therapy in mild hypertension. Use it too, as a basic therapeutic building block with which other agents can be joined, for managing your more resistant hypertensives.

Once a day, every day

ENDURON®
METHYCLOTHIAZIDE



DAILY DOSAGE RANGE	Minimum	Usual	Intermediate	Maximum
	2.5 mg. tablet	5 mg. tablet	7.5 mg.	10 mg.

See Brief Summary on final page of advertisement.

To build added response, shift to Enduronyl

ABBOTT

The deserpidine component adds enhanced antihypertensive activity

The rauwolfia component of Enduronyl is deserpidine (Harmonyl®), a purified crystalline alkaloid supplied only by Abbott. It augments Enduron with its own antihypertensive and tranquilizing action.

Thus the combined clinical effect of these two therapeutic building blocks in Enduronyl is greater than can ordinarily be achieved with either alone.

To add flexibility, Enduronyl comes in two strengths: regular and Forte. Both provide 5 mg. of Enduron. The variation is where most helpful: in the deserpidine. The tablets are scored, and give a surprisingly wide and economical choice of once-a-day doses (see below).

Choose Enduronyl for your patients in the broad range of mild to moderate hypertension. Patient acceptance is excellent!



Once a day, every day

ENDURONYL®

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.25 MG.

ENDURONYL FORTE

METHYCLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.5 MG.

DAILY DOSAGE RANGE	Minimum	Usual	Intermediate	Maximum
	2.5 mg. methyclothiazide 0.125 mg. deserpidine	5 mg. methyclothiazide 0.25 mg. deserpidine	7.5 mg. methyclothiazide 0.375 mg. deserpidine	10 mg. methyclothiazide 0.5 mg. deserpidine
DAILY DOSAGE RANGE	2.5 mg. methyclothiazide 0.25 mg. deserpidine	5 mg. methyclothiazide 0.5 mg. deserpidine	7.5 mg. methyclothiazide 0.75 mg. deserpidine	10 mg. methyclothiazide 1 mg. deserpidine

See Brief Summary on final page of advertisement.

707075-R

Eutonyl affords a different kind of basic therapy for moderate to severe cases

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Effect tied to reduced peripheral vascular resistance; no central depressant action

Eutonyl is a unique nonhydrazine agent. It is reported to act by reducing peripheral vascular resistance.[1,2]

In clinical trials, significant reductions in mean blood pressure were seen in 84% of patients studied—all were moderate to severe cases. Eutonyl lowers diastolic in proportion to systolic, and in about half of the cases studied, reductions in the sitting and recumbent positions were nearly as great as in the standing position.

Most important: There is no central depressant action. In fact, some patients reported an *increased* sense of well being.

Here, then, is a highly effective *basic treatment* for moderate to severe cases—and one that will not hamper your patient with lethargy or drowsiness while on treatment.

Once a day, every day

EUTONYL®
PARGYLINE HYDROCHLORIDE



DAILY DOSAGE RANGE	Minimum	Usual starting	Intermediate	Maximum
	10 mg. tablet	25 mg. tablet	50 mg. tablet or as needed	200 mg.

1. Brest, A. N., et al., Cardiac and Renal Hemodynamic Response to Pargyline, Ann. N. Y. Acad. Sci., 107-1016, 1963.
2. Winsor, T., Pargyline Hydrochloride, Hypertension, Urinary Tryptamine, and Vascular Reflexes, Geriatrics, 19:598, Aug., 1964.

See Brief Summary on final page of advertisement.

Eutron adds thiazide for enhanced therapy with milder side effects

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Only a 7/4 mm. span between standing and recumbent pressures in clinical trials—reduced chance of orthostatic hypotension

The combining of Eutonyl and Enduron in Eutron permits a significantly greater antihypertensive effect than with either agent used alone. This in turn may allow therapeutic success with lesser dosage—and correspondingly milder side effects.

A significant finding in clinical trials was the drug's action in lowering blood pressure to *nearly equal levels in all body positions*. Total average spread between standing and recumbent readings (after treatment) was only 7/4 mm. Hg.

Thus, in your moderate to severe cases, Eutron affords a usually smooth course of therapy, often with reduced likelihood of orthostatic effects. (The usual precautions against rising suddenly, of course, will always apply.) And, because of the thiazide component, Eutron may be used in the presence of congestive heart failure.





Once a day, every day

EUTRON™

PARGYLINE HYDROCHLORIDE 25 MG.
WITH METHYCLOTHIAZIDE 5 MG.

DAILY DOSAGE RANGE	Minimum	Usual starting	Intermediate	Maximum
	12.5 mg. pargyline hydrochloride and 2.5 mg. methyclothiazide	25 mg. pargyline hydrochloride and 5 mg. methyclothiazide	37.5 mg. pargyline hydrochloride and 7.5 mg. methyclothiazide	50 mg. pargyline hydrochloride and 10 mg. methyclothiazide

See *Brief Summary on final page of advertisement.*

TM—Trademark

ENDURON® | ENDURONYL®

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Enduron is used to control edema and mild to moderate hypertension; also used with other drugs for hypertension. Enduronyl is used in mild to moderately severe hypertension; when used with Enduronyl, more potent agents can be given at reduced dosage to minimize undesirable side effects.

Contraindications: Neither Enduron nor Enduronyl should be used in severe renal disease (except nephrosis) or shutdown; in severe hepatic disease or impending hepatic coma; in patients sensitive to thiazides. Hepatic coma has been reported as a result of hypokalemia in patients receiving thiazides.

Enduronyl is contraindicated in patients with severe mental depression and suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity reactions in patients with a history of allergy or asthma. If added potassium intake is indicated, dietary supplementation is recommended. Enteric-coated potassium tablets should be reserved for cautious use only when adequate dietary supplementation is not practical because those tablets may induce serious or fatal small bowel lesions consisting of stenosis with or without ulceration. These small bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs.

Precautions: Use thiazides with caution in severe renal dysfunction, impaired hepatic function, or progressive liver disease. In surgical patients, thiazides may reduce the response to vasopressors and increase the response to tubocurarine. Use thiazides with caution in pregnancy (bone marrow depression, thrombocytopenia, or altered carbohydrate metabolism have been reported in certain newborn infants). Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. Antihypertensive response may be enhanced following sympathectomy.

Use Enduronyl with caution in patients with a history of peptic ulcer, as rauwolfias may increase gastric secretion. Discontinue at the first sign of mental depression. Rauwolfia alkaloids may increase hypotensive effects of surgery or anesthesia, and should be discontinued two weeks prior. They also lower the convulsive threshold and shorten seizure latency. In epilepsy, dosage adjustment of anticonvulsant medication may be necessary. Alcohol, barbiturates, or narcotics may potentiate action of deserpidine.

Adverse Reactions: During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). All patients should be observed for signs of hyponatremia ("low-salt" syndrome). Reported thiazide reactions include: anorexia, nausea, vomiting, diarrhea, headache, skin rash, dizziness, paresthesia, weakness, photosensitivity, jaundice, and pancreatitis.

Reported rauwolfia reactions include: nasal stuffiness, nausea, weight gain, diarrhea, aggravation of peptic ulcer, epistaxis, skin eruption, and reduction of libido and potency. Excessive drowsiness, fatigue, weakness, and nightmares may signal early signs of mental depression.

EUTONYL® | EUTRON™

PARGYLINE HYDROCHLORIDE

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications: For treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. Not recommended for patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone. It is desirable to establish the dosage of Eutron by administering component drugs separately.

TM-Trademark.

Contraindications: Pheochromocytoma, advanced renal disease, increasing renal dysfunction, paranoid schizophrenia and hyperthyroidism. Hepatic coma has been reported as consequence of hypokalemia with thiazide therapy. Until further experience is gained not recommended for patients with malignant hypertension, children under 12, or pregnant patients.

Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. 2 week interval should separate therapy and use of these agents.

Methyclothiazide is contraindicated in patients with known sensitivity to thiazides.

Warnings: Pargyline hydrochloride is a monoamine oxidase inhibitor. Warn patients against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When indicated, alcohol, narcotics (meperidine should be avoided), antihistamines, barbiturates, chloral hydrate, and other hypnotics, sedatives, tranquilizers, or caffeine, may be used cautiously in reduced dosage. In emergency surgery ¼ to ⅓ the usual dose of narcotics, analgesics, and other premedications should be used avoiding parenteral administration where possible. Carefully adjust dose of anesthetics to response of patient. Withdraw pargyline two weeks before elective surgery.

Warn patients about the possibility of postural hypotension. Those with angina or coronary artery disease should not increase physical activity with an improvement in well being. Pargyline may lower blood sugar.

Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions consisting of stenosis with or without ulceration. These small-bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs. These products contain no added potassium salts and if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical. In patients with a history of allergy or asthma the possibility of sensitivity reactions should be considered.

Precautions: Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields and fundi. Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. In surgical patients thiazides may reduce response to vasopressors and increase response to tubocurarine.

Adverse Reactions: Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extrapyramidal symptoms have been reported in a few patients with reduced cardiac reserve.

During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). Observe all patients for signs of hyponatremia ("low salt" syndrome).

Reported thiazide reactions also include anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, and pancreatitis. Nocturia has been observed with the combination.

709075R

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Each OBETROL-10 tablet contains: Methamphetamine Saccharate; 2.5 mg. Methamphetamine Hydrochloride; 2.5 mg. Amphetamine Sulfate; 2.5 mg. Dextro-amphetamine Sulfate; 2.5 mg. (OBETROL-20 tablets contain twice this potency) Pat. #2748052.



This combination of amphetamines may be useful as an adjunct in the management of certain forms of obesity where an appetite depressant is indicated.

Contraindications: Hypertension, advanced arteriosclerosis, coronary artery disease, cardiac arrhythmias, peripheral vascular disease, states of undue restlessness, anxiety, excitement, agitated depression, hyperthyroidism, idiosyncrasy to amphetamine, concomitant administration of a monoamine oxidase inhibitor. **Precautions:** Use with caution in individuals with anorexia, insomnia, vasomotor instability, asthenia, psychopathic personality, a history of homicidal or suicidal tendencies, and individuals who are known to be hyperractive to sympathomimetic agents, or emotionally unstable individuals who are known to be susceptible to drug abuse. Certain monoamine oxidase inhibitors may potentiate the action of Obetrol. **Side Effects:** The most common side effects attended with the use of amphetamines include nervousness, excitability, euphoria, insomnia, dryness of mouth, nausea, vertigo, constipation, and headache. **Dosage and Administration:** Initial adult dose is one-half to one 'Obetrol-10' tablet daily, preferably one-half to one hour before meals. This may be gradually increased to one 'Obetrol-10' or 'Obetrol-20' tablet one to three times daily as indicated. **Supplied:** Tablets scored, in bottles of 100, 500, and 1000.

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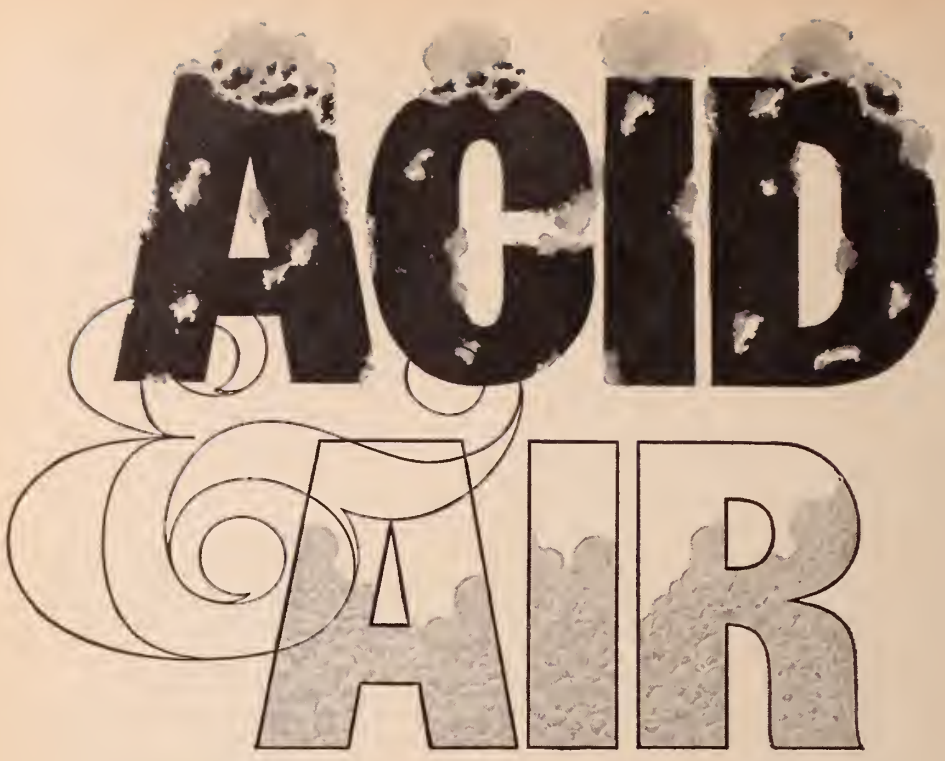
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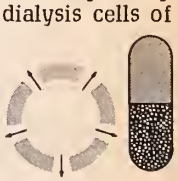


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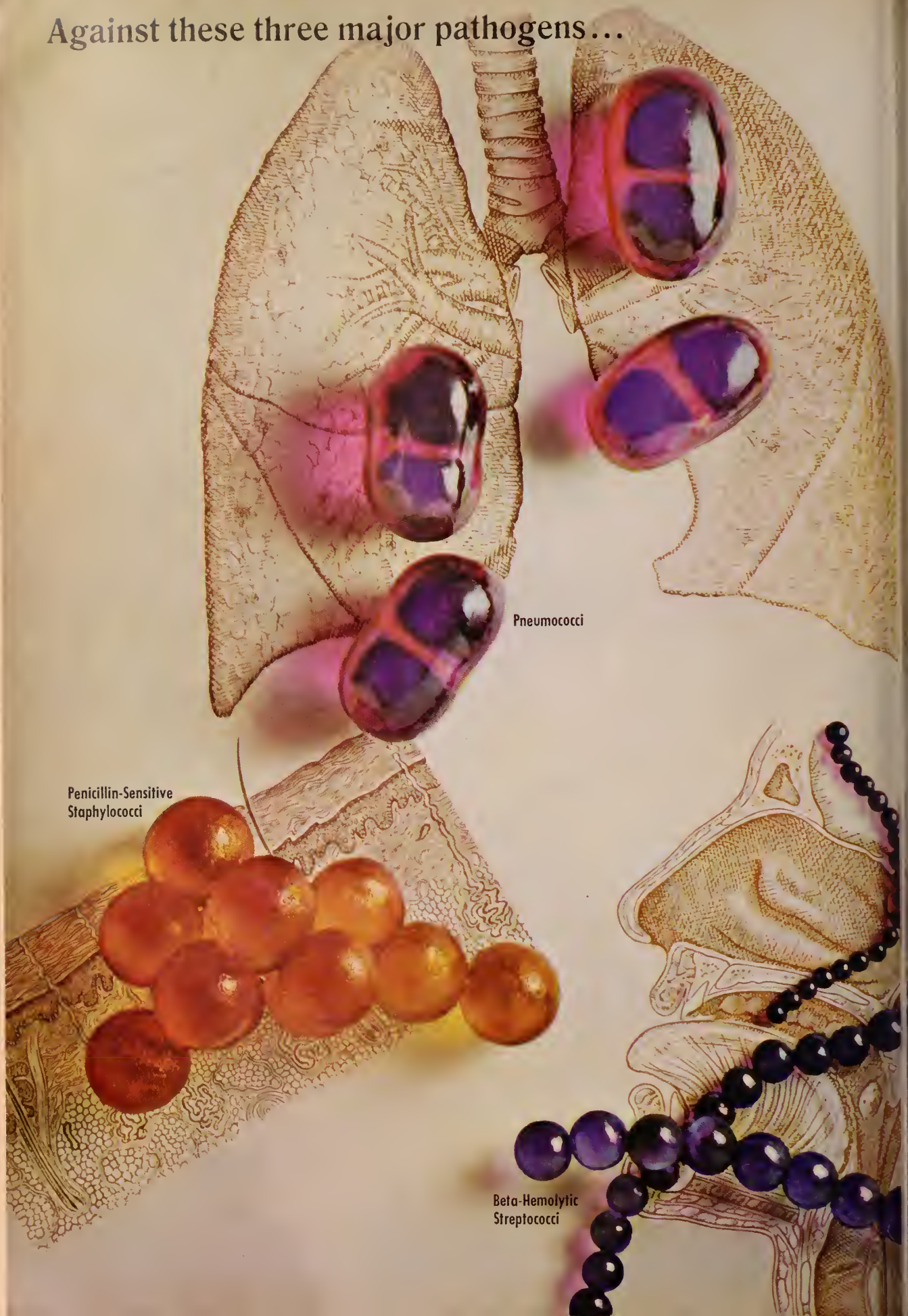
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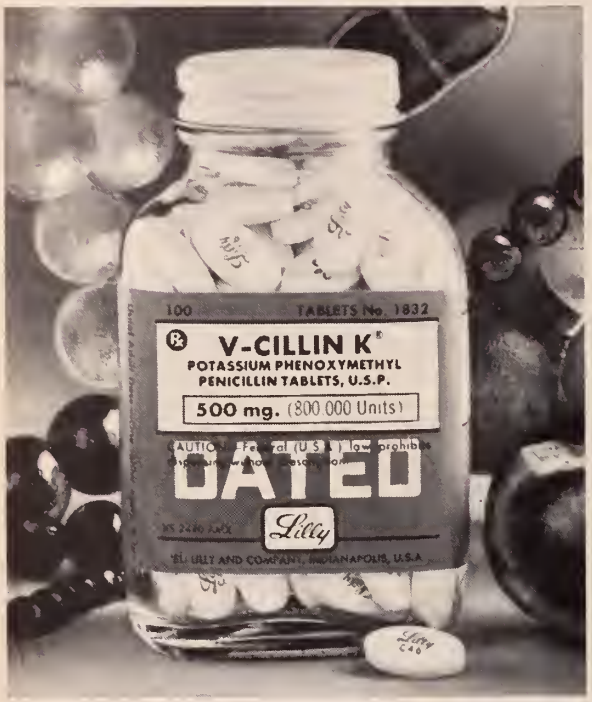
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Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

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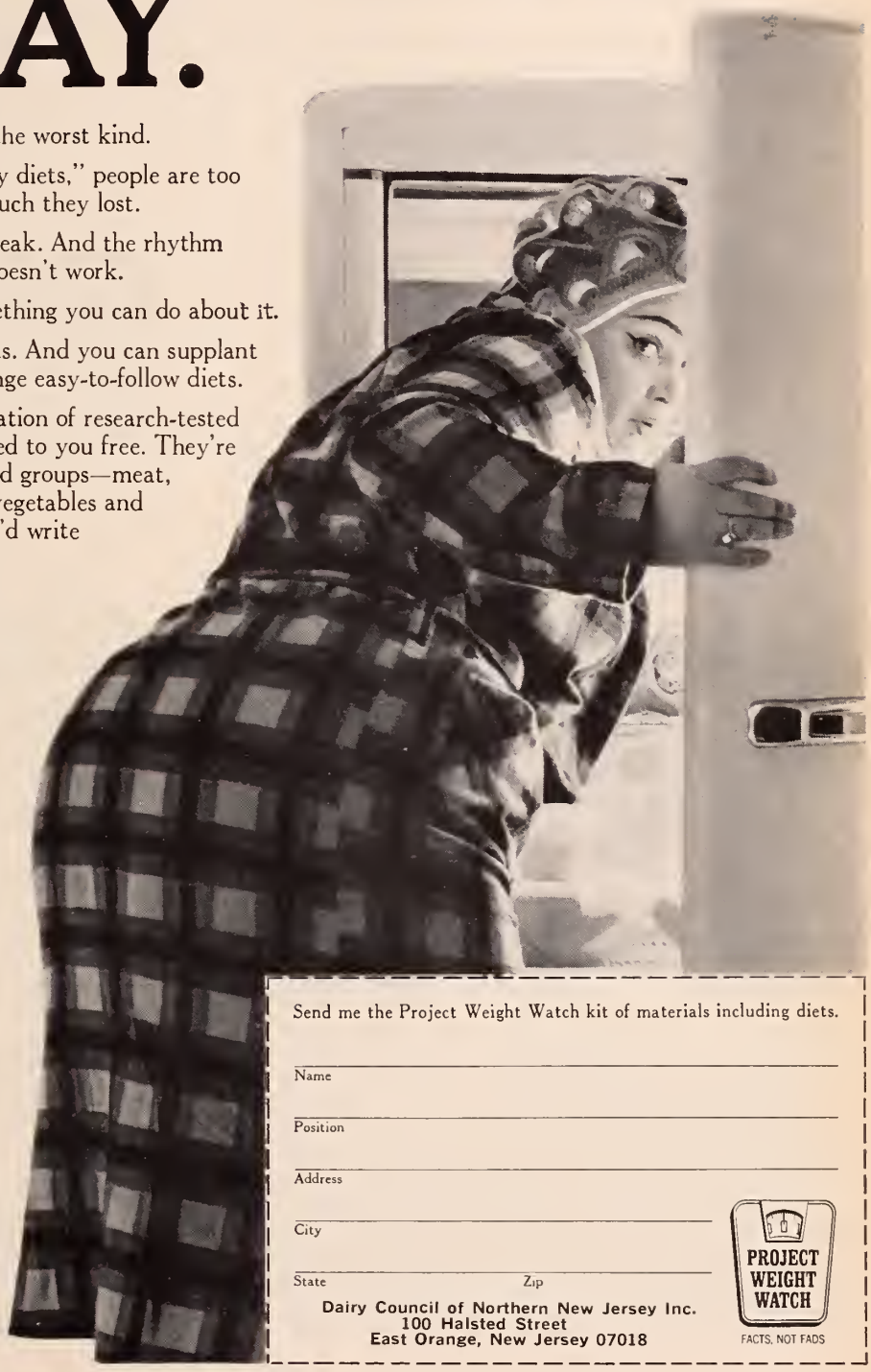
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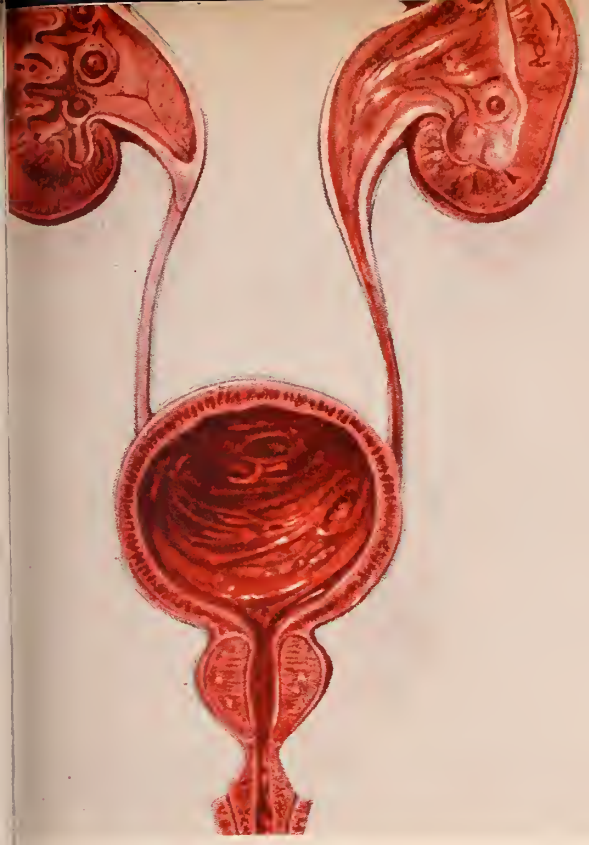
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nces: (1) Based on 23 clinical papers, 1512 cases. Bibliography on re-(2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: crobial Agents and Chemotherapy—1964, Ann Arbor, American Society crobiology, 1965, p. 722.

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Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

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Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make regular blood counts. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Purpuric rash has also been reported. Agranulocytosis, ex-

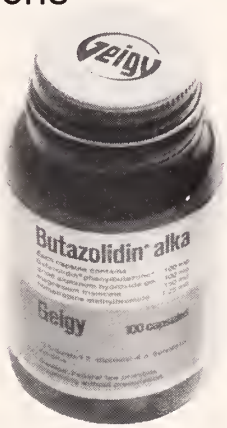
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foliative dermatitis, Stevens-Johnson syndrome, or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Rheumatoid Arthritis: Initial: 3 to 6 capsules or tablets daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules or tablets daily; response is often achieved with 1 or 2 capsules or tablets daily.
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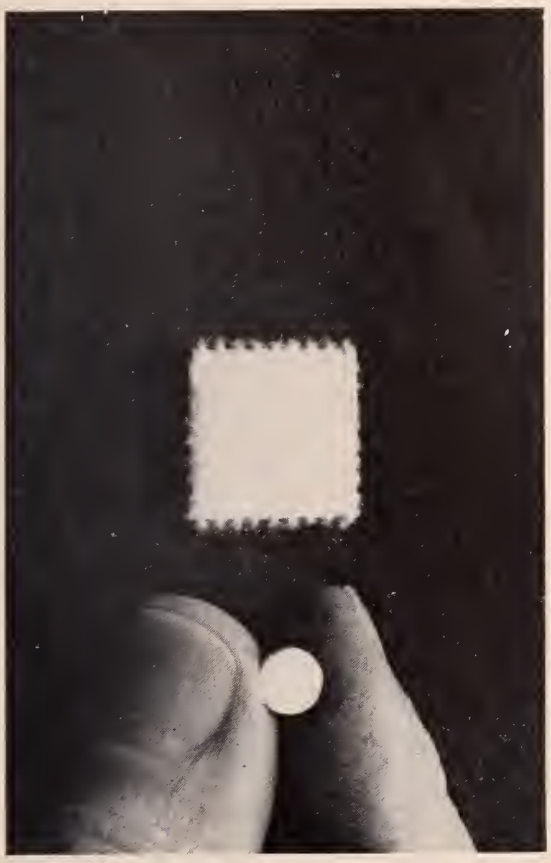
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EDITORIALS

The New Bigotry

Practically everybody considers himself a "liberal" and practically every liberal condemns bigotry and prejudice. This phrase, "bigotry and prejudice," one must assume, refers to a general condemnation of an entire class based on a preconviction that the group is inherently evil. And no liberal would be caught entertaining any such "prejudgments." Not against any ethnic or religious group that is. But there is one field where the liberal may be prejudiced to his heart's content. That is in distrusting physicians. Here he may accept, as an article of faith, the thesis that physicians are inherently greedy and that all their opinions and actions are based on self-interest in the most unenlightened sense of that term. Indeed, it is even "smart" for the liberal to cling to such notions. Typically, he will reject the possibility that physicians, individually or in groups, are motivated by any honest dedication to public welfare.

If the doctor, for himself or as spokesman for a medical society, says that compulsory health insurance leads to second rate medical care, the prejudged answer snaps back: the doctor says that because he is prosperous under this system and doesn't want to reduce his income. If it is pointed out that the destruction of free choice removes something fine (and something therapeutically useful), the answer is that this is a myth dreamed up by physicians to protect their own interests.

Indeed, the "liberal" in such a context will not even concede that the physician might be honestly mistaken in his attitude. He will have it that the doctor takes this position out of greed, and deny that any physician who opposes expanding health insurance could possibly be honorably motivated. If you point out that physicians are forever doing things against their own interests, you get laughed at. If you dare mention the vast amount of gratis work done by every M.D., you are told that this is being patronizing, or that this is simply the result of a bad conscience. If you repeat stories of personal devotion, hours of unremitting and unrewarded vigil, or of personal exposure, you are told that this is pure corn.

No example of heroism, sacrifice, or selfless dedication to patients will make any difference. For the critic has already made up his mind. He has judged — indeed he has prejudged. And in the purest sense of the word, this is "prejudice." But it is the new prejudice, the permitted prejudice, even perhaps the fashionable prejudice. It is, furthermore, the safe prejudice, for the critics can be sure that no matter how hostile their tone, how unfair their condemnation, there can be no retaliation. For medicine's indispensable benefits are for friend and foe alike.

Don't Let Them Count You Out

This month you will receive (if you haven't received it already) a form for the 1968-1969 *Membership Directory*. Some 4½ per cent of you will fail to return the form; the other 95½ per cent will cooperate. When the form is not returned, the Secretary of the Society will have to use whatever data he has from older forms or previous directories (or omit your address and so forth entirely). Then you will complain that the Secretary's office (no, it isn't this JOURNAL's office) made a mistake in your listing.

If you don't send in the data, you may be counted out. Or you may get only a skeleton listing, and perhaps it won't be a very good skeleton at that.

Please join the other 95 per cent. Send in your data sheet by the date indicated; or forever hold your peace!

The High Cost Of Medical Education

In medical education, the skyrocketting costs are not threatening the potential student as much as they are the schools themselves. Figures recently released by the Association of American Medical Colleges show for the period of 1964 to 1965 an all time high level of operating costs of medical schools. Federal contribution is proportionately small. If medical manpower needs are to be met, all sources of support for the medical schools must increase their giving, and better mechanisms for obtaining unrestricted funds must be developed.

Actually, the major sources of largess in our affluent society are government, the foundations, and big business. One hesitates to ask our colleges and universities to line up, hat in hand, for substantial contributions from any of these three sources. The dangers would appear to be obvious.

Medical school expenditures for regular operating programs in 1965 reached a new high of $319.7 million, an increase of 12 per cent over the previous year's expenditures. Regular operating program expenditures are made in support of the education and service function of the medical school from such intramural fund sources as state appropriations, general university funds, gifts, grants, tuition, and endowment income. Both state supported and privately supported medical schools are having increasing difficulty in meeting the mounting costs of regular operations and the increasing demands for expanded educational programs. Congressional recognition of this need resulted in the amendment in 1965 of the "Health Professions Educational Assistance Act," enabling the Surgeon General to make basic improvement grants to U.S. medical schools to support regular educational programs. In 1966, a total of $6.6 million was awarded to U.S. medical schools or an average of $76,000 per school. These federal funds have served to meet only a small portion of the need for additional support.

Medical societies are generally uneasy over support of medical education from foundations, government, or industrial sources, and it would seem to be the better part of wisdom to help medical schools through our own contributions — as individuals, as organizations, and as alumni. We in New Jersey have already seen one medical school that was too expensive for its sponsoring university and this is understandable. Because a medical school is usually a heavy drain on its budget, many universities have refused to start such schools. They recognize the prestige value of a medical school but fear that the price tag is too rich for their blood.

In the last analysis, medical education must remain in the control of medical people. The purpose of a medical college is to train physicians to take care of sick people. And no one can train a medical practitioner except another medical practitioner. And this, perhaps, is where we come in.

Occupational Mental Health

Th executive suite can sometimes be a torture chamber for the executive and his family. Business demands often force him to neglect his family to the point where one top medical officer of a large firm says: "We're ruining a lot of families." Nor is the executive the only one who suffers "industrial fatigue." Blue collar workers, too, trapped in the endless repetition of the same operation on the assembly line sometimes suffer mental collapse or fail to function at normal levels.

Such problems have led to development of the new field of occupational mental health. Dr. Stanley F. Yolles, Director of the National Institute of Mental Health, speaking at the pioneer National Conference on occupational mental health said: ". . . industry is now becoming aware that the relationship between a man's work and his mental health is basic; both to human satisfaction and to industrial productivity."

To keep the scientific professional community abreast of developments in the growing field, the NIMH's National Clearinghouse for Mental Health Information periodically publishes "Occupational Mental Health Notes." This is beamed at both physicians and executives in labor and industry.

In this field, every one seems to want to get into the act. Vocational counselors, psychologists, clergymen, social workers, industrial nurses, labor union executives, and personnel officials are all interested in occupational mental health. Doctors of medicine have, for a century, staked out a claim to concern with industrial health. Let it be hoped that this new and challenging subspeciality will also hold the interest of physicians.

De Senectute

Some years ago, Peter Medawar* tried to find one person who had died of old age. He was not successful. Indeed, no one has ever died a "natural" death from old age. Diseases like arteriosclerosis have caused deaths in old people. But nobody (that is, no body) ever quit because it was too old. Since we won't admit that any disease is forever destined to be incurable, we would have to conclude that sooner or later most people will live well beyond the century mark.

Ironically, the science of studying the aged — geriatrics — is the youngest of our specialties. We know a little about slowing down the aging process. "Rats kept in a chilled environment live longer than those at room temperature because their metabolism is slowed."* Colonies of tissue cells can be kept alive in the laboratory and outlive the organisms from which they were taken. "A little starvation might be good for us. Starved rats outlive their fattened cousins."*

We don't know whether the liveliness of some old people (Maurice Chevalier, let's say) is a result of their living longer or a cause of it. Certainly Winston Churchill was making an enormous contribution to shaping the destinies of mankind at an age when private industry would have put him out to pasture. Apparently one thing that keeps old people alive and well is a sense of involvement in the world — though whether the sense of involvement precedes the aging process, no one can say. Drive, motivation, challenge (look at the challenge that faced Winston Churchill in 1942 and 1943), seem to be the vitamins on which old age is nourished.

Some years ago, a poem by the late W. R. Greeley was published in the *New England Journal of Medicine.*** This verse on the subject, as one gets older, seems somehow consoling.

Deft of finger, full of fire,
Old Socrates at seventy-one
Set out to learn the Lute and Lyre
And found it hard but lots of fun.

Armed with pep and self-reliance
Tom Edison at seventy-six
Began to build a weird appliance
To telegraph across the Styx.

Great Grandma Moses, young at heart,
Got tired of chores at seventy-eight,
She found some paint and turned to art,
And now her pictures hang in state.

Round of paunch and keen of wit
At eighty Franklin chaffed the boys
And guided them (and William Pitt)
With perspicacity and poise.

Spry of foot, of eye tenacious
King Gustaf played a game so mighty
He snatched top laurels from teen-agers
Nor layed his racket down till ninety.

And don't forget revengeful Cato
Who always knew just what to do
He was another late tomato
Who mastered Greek at 82.**

Our progession has gone far toward conquering infant mortality. Next step — to conquer age. Jean Paul Richter once said: "What makes age sad is not the end of joy, but the end of hope."

* From the AMA publication "Live Longer and Like It," part of the "Science Feature" series prepared by their Department of Science News.

** The verse was published in the February 11, 1960 *New England Journal of Medicine.*

ORIGINAL ARTICLES

A good communications network, and sound regionalization of control are the secrets of good disaster and emergency medical care.

Community Emergency Medical Care

Jack R. Karel, M.D./Hillside*

Over the years I have been in the field of disaster medical care, and I now sense a need for change in our thinking toward this subject. With the advent of the nuclear age, there seemed to be a need for a new organization to cope with the tremendous number of casualties that might occur and to develop technics and capabilities that could function under austere conditions.

Reviewing what went on in the 1950's, I conclude that what we considered as apathy on the part of the public was not really indifference at all. Something new that required perception and great comprehension has come forth, something that could not be grasped as readily as other things. Here was a whole new philosophy of thought and living required by our entrance into a nuclear era. Here is a whole new way of life to be with us forever! Such an emotional commitment was not going to be easy for the average person. It calls for a gradual educational process over a period of time. This educational process is needed by the average citizen; and is even more necessary for public officials, from federal level to the municipality, and also for all in the field of emergency medical care.

We find that the "spontaneous generation of a new organization was not required, but the augmentation of an existing day-to-day community emergency force."[1] Many natural disasters — fires, floods, tornadoes, earthquakes, explosions — daily threaten our way of life. These emergencies are always with us. They furnish opportunities for experience through which we can improve our civil defense for the greater nuclear disaster. Crash programs are not necessary. Instead we need continuous on-going training with the small emergencies appearing in every hospital emergency room.

Thus in the field of disaster or emergency medical care, we must look to the elements of training and organization that will prepare us for those greater disasters that will demand and tax our community medical resources. In disasters of all sorts, the public looks to the emergency departments of community hospitals. This demands the implementation of an emergency medical care program in every hospital with emphasis on and around the emergency room. In this, the Trustees of The Medical Society of New Jersey[2] have documented their leadership as a formal medical organization for a great constructive emergency medical care program in every hospital in New Jersey.

What elements for organization and training will prepare us for disaster? One is the development of plans and emergency rooms in hospitals that can cope with many casualties. This will demand good "coordination, communications, and counseling."[3] We urgently need individuals who are properly trained in first aid. The usual teaching of ambulance attendants is inadequate; we must include items in anatomy and physiology. We must explain *why* certain technics are performed in addition to those listed below:

* Dr. Karel is Chairman of our State Society's Committee on Emergency Medical Care. He is also the Deputy Coordinator for Union County's Civil Defense and Disaster Control.

1. Transportation of patients
2. Control of hemorrhage
3. Restoration of airway
4. Dressing of wounds
5. Burns
6. Splinting of fractures
7. Treatment of shock
8. Head, chest, and abdominal injuries
9. Childbirth

Because of the importance of *adequate* training of ambulance attendants, teaching will soon be standardized and intensified by the efforts of the National Academy of Sciences (National Research Council) working in conjunction with the American Medical Association and the American College of Surgeons. *Responsibility for this training must rest with each component medical society of the state.*

To have an effective community emergency medical care program to cope with *any* major disaster there must be a strong, well coordinated communications system to bind together all those elements and organizations working to the same end. To accomplish this unity of purpose, we must consider the existing communications resources and develop detailed plans for the effective use of these systems. Actions should then be taken to link these systems for an integrated network with a central point of control. Our Federal Government has recently promulgated actions that may be taken by counties and other large communities to receive financial assistance for *effective* planning and for the communications systems. To obtain this financial assistance, the central control point must exist in the civil defense organization. For an integrated communications system, the following agencies must be included: police departments, county and municipal civil defense communications network, county medical society, hospitals, and the district first aid council (rescue squads).

The potential of a strong network can be present when all the police departments in a county are on the same frequency. This was recently accomplished in Union County, New Jersey. With one call, all the municipalities in this county of 550,000 population may be alerted. At the same moment, the message gets to the entire county and municipal civil defense organizations. This is an example of its use in a great disaster. There should be a direct radio link between the police departments and the county civil defense office. Every hospital in a county or large city should be in the radio network and all on the same frequency. The base station may be in one of the hospitals with links to the other hospitals; or at the county medical society office, or at the county civil defense office. Other plans may also be feasible, but they must be planned.

In New Jersey when there is a declaration of state emergency (or when a national emergency is declared) the county civil defense office becomes the controlling point for all resources in the county as well as the coordination of all effort, except when superseded by state and federal resources plans.

Our final consideration now rests with the rescue squads in the community. Two-way radio must be available in each ambulance to maintain contact with all hospitals. Only in this way can equitable distribution of patients be made. In time of great disaster, with excessive numbers of casualties, bedlam would ensue otherwise.

Conclusion

A community emergency medical care program, can be available with an on-going daily program built around the emergency departments of all hospitals, good training of ambulance attendants in first aid and, most important, a well coordinated and integrated communications network.

Bibliography

1. Personal communication, Thomas D. Holman, Committee on Disaster Medical Care, American Medical Association.

2. *Journal of The Medical Society of New Jersey*, 64:230 (May 1967)

3. Personal communication

115 North Avenue

Alcohol, says Dr. Canavan, is a "permanent, irreversible, life-long disease. He finds that the Alcoholics Anonymous group offers the best hope for control.

Care Of The Chronic Alcoholic*

David I. Canavan, M.D./Oakland

Rehabilitation of the alcoholic starts the moment the patient begins to recover from the acute phase. Your success in re-integrating the alcoholic into the everyday world of his family, his job, and his associates depends, above all, on a sound understanding of the problem. The stark reality about chronic alcoholism is that it is a permanent irreversible lifelong disease. It is even possible that an inborn biochemical defect may eventually be demonstrated as its basis, analogous to other inborn errors of metabolism such as glucose-6-phosphate dehydrogenase deficiency. This is the enzyme deficiency which predisposes to acute hemolysis when a person takes drugs like primaquine or ingests fava beans.

Once you accept the concept of alcoholism as a permanent (and therefore incurable) disorder, your only recourse in treating your patient is to require total abstinence. Without this, all other therapy is valueless. The efforts of the physician are therefore directed solely to support the patient in his lifelong abstinence from alcohol in any form. It is rare for an alcoholic to accomplish total abstinence on his own. Experience with 12,000 alcoholics admitted to the Mount Carmel Hospital in the last twelve years has made it abundantly clear that the alcoholic exhibits personality traits which favor his return to alcohol as a psychological support. He is dependent constantly for emotional and moral support on other people and on other things besides himself.

Psychotherapy

Theoretically, psychotherapy might be expected to help him overcome this attitude of dependency. In some cases indeed, psychothereapy is essential. This would be true when the patient's alcoholism is symptomatic of some underlying mental illness such as a severe anxiety reaction or outright schizophrenia.

When alcoholism itself is the basic problem, psychotherapy cannot be expected to remedy what is actually a personality defect rather than a mental illness. The alcoholic, being immature emotionally, narcissistic, dependent, and basically insecure, finds it necessary to hide continuously behind the bottle. This gives him rose-colored lenses to face life. In many instances, the alcoholic is a highly intelligent person, extremely competent in his normal field of activity. His problem arises when he is faced with the need to cope with the inevitable conflicts which are part of ordinary living. What he says to himself in effect is: "If I can't have my way I won't play."

The psychiatric approach is inadequate for this type of make-up, in the majority of instances. Occasional remarkable accomplishments can be achieved by psychiatry. To a large extent this depends as much on the willingness and ability of the patient to participate in the process of solving his own problem.

*The is the second paper in the symposium co-sponsored by the State Health Department and the Academy of Medicine of New Jersey, held at the Middlesex General Hospital in New Brunswick on February 14, 1967. Dr. Canavan is Medical Director of the Mt. Carmel Hospital in Paterson.

Aversion Therapy

A number of short cuts have been devised in the hope of overcoming alcoholism by indirect approaches. For example, *drug therapy* with disulfiram (antabuse®) or, preferably, Temposil,® has been developed in the effort to make alcohol unacceptable to the alcoholic. The action of disulfiram is to block the catabolism of alcohol at the acetaldehyde stage, producing extremely unpleasant symptoms. The alcoholic is instructed to maintain a continuous intake of Antabuse® or some similar pill which will make him extremely uncomfortable with even the smallest amount of alcohol. The eventual result of this program, is evasion.

The alcoholic is a notoriously efficient "con man". With a straight face he will maintain that he is scrupulously taking the drug when, all the while he is holding it in his cheek awaiting an opportunity to spit it out. One can hardly blame him. Once he has experienced the shock-like drop in blood pressure, the sweating, vomiting, and other extremely unpleasant symptoms of acetaldehyde poisoning, he feels strongly importuned to avoid the disulfiram. He has probably heard tales of fatal results from its use after alcohol is taken.

The possibilities of hypnosis have aroused interest as another indirect approach. The underlying principle here is that post-hypnotic suggestion may cause the alcoholic to resist taking a drink because of the suggestion that this will cause him to vomit. However, he soon finds that the effect does not last unless revived every 4 to 8 weeks; even then it may be ineffective.

Conditioned reflex treatment has also been tried. The patient is given an emetic drug like apomorphine, with each dose of alcohol during a trial period. This is done until he is conditioned to the idea that alcohol makes him sick. This "conditioning" is effective in certain instances but as a rule it works better in cats and rats than in humans.

Efforts to alter the alcoholic personality by hallucinogenic drugs including LSD are still in an experimental phase. Enough information has not yet been accumulated to determine their possibilities. Some authorities believe that metronidazole (tradenamed Flagyl) produces an aversion to alcohol, and a few reports have been published suggesting its use in milder cases.

Alcoholics Anonymous

Beyond any doubt, the one organization which has achieved greatest success in combating alcoholism is that which is commonly known as "AA". It is composed of sober alcoholics who have been through the degradation and despair that every alcoholic knows. They are therefore rich in their understanding of the problems which confront the victim of the habit. Furthermore, the organization has achieved commanding prestige by reason of its successes. It offers hope where no hope exists otherwise. The organization provides also a camaraderie of suffering and experience which supplies one of the greatest needs of the alcoholic, a person who feels himself to be rejected by society. To benefit from the services of "AA", the alcoholic must be certain that he wants to achieve and maintain sobriety and must be willing to seek such outside help as is available. Next, he must accept the fact that he is actually an alcoholic. To accept this is often the biggest obstacle to his rehabilitation because of what it requires from him: a tremendous act of self-abasement and humility. Often the alcoholic is too proud to acknowledge the existence of his alcoholism or to admit being defeated by it. The self-deception is another aspect of the skill achieved by most alcoholics in the art of deception inverted now upon themselves. Much of the thinking of the alcoholic is governed by false pride and intellectual dishonesty until he reaches the point where he is willing to accept the idea of living a life without alcohol. This is not an easy pill for him to swallow, particularly since it implies a certain measure of inferiority compared with other people and the sense that he is undeserving of such a fate.

The objectives of "AA" are to teach the alcoholic the need of coming to the realization of the facts and the wisdom of staying sober—not forever, but *for one day at a time.* Once this has been achieved, the alcoholic can proceed then to work on the next day when it arrives, and so on. "AA" provides a place for the alcoholic to go, often to enable him to spend time profitably when he has time to spare rather than to repair to the gin mill. The educational effect of "AA" is vastly more effective because the education is imparted by people who have traveled the same road and have demonstrated the possibility of success.

One of the strongest elements in "AA" is the moral support it provides the sufferer, especially during crises when he is confronted with the temptation to take the first drink. No one is more selfish than the confirmed alcoholic who is willing to sacrifice friends, family, prestige, and security for his habit. The membership of "AA" provides the very opposite in their example of utter selflessness and willingness to make themselves available for the sake of others. Part of the education of the alcoholic is therefore the embodiment of this principle, the strength which he attains when he has learned to help others and therewith the recognition of the truth that one learns most who teaches. In teaching others as a member of "AA", the alcoholic learns much more about himself.

Finally, "AA" assists the alcoholic by opening to him the door of spiritual rehabilitation. Although not truly a religious organization, "AA" helps the alcoholic develop the concept of a higher power upon which he may depend in time of need. This, in fact, may constitute the most successful element in the "AA" program, particularly when the one involved is sincerely motivated.

Role of the Physician

Often the first person to see the alcoholic patient is the physician. Willing or not, the medical practitioner has the obligation of making himself competent to handle the problem. The first thing he must know is where to turn for help. Lack of such knowledge may cause incalculable waste of time and money. Management of the acute problem was discussed in last month's Journal. It involves treatment of the acute intoxication and of its withdrawal phase, diagnosis and treatment of head injury and intercurrent disease or complications, the correct use of sedatives, tranquilizers, and anticonvulsants.

The long range management of the alcoholic following either the acute episode or during the chronic phase of the problem requires the energetic participation of the physician. If the physician is concerned primarily with just keeping the alcoholic patient quiet and getting him out of his office, he may prescribe some sedative such as promazine and send the patient on his way. In practically every case, this leads nowwhere. The worst thing that can be done is to give the patient a tranquilizer and an admonition and hope for the best. In almost every case, the patient returns to alcohol now combined with a tranquilizer. He may even take the entire dose of tranquilizers at once and bring himself into a state of coma which may prove fatal.

The proper role of the physician is to treat the patient as an urgent medical problem beginning with complete withdrawal of alcohol, administration of necessary tranquilizers and food supplements, and institution of a well thought out program of total permanent abstinence. This may be done best by sending the patient to a properly constituted hospital for this purpose where he can receive adequate psychiatric help, if required. If no deep seated psychosis exists, perhaps the first measure should be to establish liaison for the patient with the nearest "AA" group. To this end the physician should possess the necessary names and telephone numbers.

This paper and Dr. Bissell's (see November JOURNAL page 604) were discussed in a panel presided over by Dr. Sylvan Moolten. An abstract of this discussion follows:

Discussion

The magnitude of the problem is hardly realized by most people. The bill for alcoholism in the United States is estimated at over one billion dollars a year—in work time lost, accidents, reduced and spoiled work

output, and welfare payments to families of non-working alcoholics. This is a direct economic cost only. It does not cover crime attributable to alcoholism nor such immeasurable losses as the human misery in interpersonal crises, broken homes, frustrated children, warped personality, and dulling minds. For a vivid discusson of this see, "Robber of 5 Million Brains," an article by Milton Golin in the July 1958 JAMA, (167:1496)

In his relation to the alcoholic patient the physician is more than a doctor. He is also a citizen, with overriding responsibility to make every effort to salvage the victim of this disease. By applying himself to the problem, the practitioner is saving not merely a patient but also a family and families to be and salvaging an integral element of the community in which he may be benefiting the lives of many people he may never know or even see.

The physician's willingness to assume the burden cannot be undertaken without complete understanding and with the realization that in all honesty the physician by himself is unable to cope with the problem but must enlist the aid of the large number of medical and non-medical resources.

Unfortunately, most physicians are amateurs until they have given deep thought to the subject and learned the lesson of humility, especially the need to seek guidance and help from those who are more experienced. The employment of such resources must not be deferred until the patient is ready for discharge from the hospital. By that time the golden moment may be lost. Rehabilitation of the alcoholic must be commenced from the moment that the subject is able to participate actively in his own salvage. The extent of the problem in the area about New Brunswick and in Middlesex County is hard to assess. Perhaps the only facts — and these are hard brutal facts — are autopsy statistics. Evidences of the seriousness of this problem are contained in an evaluation summary of cases listed in the office of the Middlesex County physician. Dr. William O. Wilentz, based on a 33-year span (1936 to 1966). During this time, Dr. Wilentz gathered material on 5,000 violent deaths. Of these nearly one third were associated in some degree with the factor of alcohol (1,540 cases out of a total of 4,978). The alcohol content was determined in the brain, cerebrospinal fluid, liver, or blood. In 56 per cent of cases the subject was known to have been drinking, i.e. had an alcohol concentration up to 0.15 milligrams per cent. In the remaining cases (44 per cent) the subject was definitely "under the influence" of alcohol, as indicated by the presence of alcohol at a level of 0.15 milligrams per cent or higher.

Not all of the cases in Dr. Wilentz's series were the result of automobile accidents. Although these accounted for about one third of the total violent deaths, they constituted just about half the deaths involving motor vehicles. Among 190 deaths by drowning, 113 were associated with alcohol. In 70 out of 248 homicides, alcohol was also a factor. Suicides, in many instances, were associated with alcohol (188 out of 542 suicides) but, in addition, yielded evidences of use of barbiturates and other drugs or exposure to carbon monoxide.

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Soapless Baby Bathing

In *Medical Officer* (115: 279, Feb. 1966), H. T. Calvert and three colleagues suggested that our traditional soap and water method of baby-bathing is all wrong. It takes too long; it makes the baby slippery (thus leading to anxiety and tension in the mother lest the baby be dropped); soap will get into the baby's eyes (thus turning him against all baths); and there is a scum on the bath due to interaction of soap with hard water. A mixture of hexachlorophene and allantoin in the bath water does away with the need for soap. There is no loss of body heat during preliminary soaping. This method reduces the colonization of skin by harmful organisms.

Hexachlorophene has been advocated for the bathing of newborn babies for years. The American Academy of Pediatrics has stated that, "Hexachlorophene-bathing probably reduces the rate of skin and nasal colonization by staphylococci and possibly lowers the incidence of skin infection in newborn infants." Many have advocated that new-born babies should not be bathed at all. Some recommend the total omission of bathing in the whole newborn period, after initial removal of blood and mucus. The buttocks were to be cleansed with mineral oil or water. Another pediatrician found that the no-bathing technic did not increase the incidence of rashes, pustules, or paronychiae, and commended the method because it saved so much time.

Mothers will continue to use soap and water because it is traditional—in spite of the fear that they (or their husbands) will drop the baby. In the nursery for newborn babies many will prefer the no-bath technic or the use of hexachlorophene.

If emotional, social, or economic factors make it advisable to prevent the birth of additional children, it is suggested that wider contraceptive information is better than abortion.

An Obstetrician's View Of Abortion*

John D. Preece, M.D./Trenton

As physicians we belong to an honorable and dedicated profession. From the time of Hippocrates, our role has been the protection of life. This is emphasized in the training of every physician — a constant fight for the preservation of life. It is a never-ending dedication — in the emergency ward where battered bodies are brought gasping for air; in the operating room where surgeons struggle to preserve the life of an aged person suffering from cancer; or in the premature nursery where the entire staff strives to maintain life in the one and a half pound premature infant. I do not mean to say that relief of pain, patient counseling, and hygenic guidance are not also important; but all become secondary where life is imperiled. This is the role of the man of medicine in our culture. The Judaeo-Christian society in which we live is based on the principle of the sanctity of human life. This has been the foundation of laws, our religion, and the entire fabric of our civilization.

Our society makes only few exceptions where life may be sacrificed. It is permissible (1) in self-defense, (2) in war, (3) in capital punishment, and (4) in therapeutic abortion (where the destruction of a fetal life is acceptable if it is necessary to preserve the life of the mother).

The necessity for the deliberate destruction of fetal life has always been one of the great frustrations of the obstetrician. From the first lecture in obstetrical training, he is informed that he is different from other doctors in that he has not only the life of the patient to protect, but that he is responsible for two lives, the maternal and the fetal. He is constantly reminded that his treatment of the pregnant woman must always be tempered by the realization that no treatment is good that would endanger the life of the fetus. His objective must be the delivery of a healthy woman of a living, healthy infant. Anything less than this must be accepted as a failure, or partial failure, to attain the perfect obstetrical result.

With this realization in mind, the obstetrician of 30 years ago was confronted by the realization that certain maternal diseases were accepted as too dangerous to be compatible with a successful pregnancy. In those days rheumatic heart disease, pulmonary tuberculosis, and pernicious vomiting of pregnancy were accepted as indications for therapeutic abortion. This proportion of failure in attaining the ideal obstetrical result was high enough that certain men withdrew from the practice of obstetrics, rather than face this dilemma. It has been through a series of great achievements in medicine in the past 30 years that these three indications for therapeutic abortion have practically disappeared. This realization within my own short life in medicine gives me more pride in my profession than I can ever describe, because it has shown the true spirit of medicine and the

* Presented November 1, 1967 as one of a series of discussions on abortion under the aegis of the YWCA in Princeton, New Jersey. Dr. Preece was speaking as an individual and not as a member of MSNJ, and the views here offered do not, of course, reflect the official position of The Medical Society of New Jersey.

ability of the physician to cure the cause for the abortion and not to accept anything less than the perfect objective for which all obstetricians strive.

Unfortunately, new indications for therapeutic abortion have arisen in the last few years. The discovery that rubella, in the early months of pregnancy, resulted in a large proportion of mal-formed infants at birth has become an indication for interruption of the pregnancy. The RH sensitized mother also became a subject for abortion where repeated pregnancies resulted in severe fetal erythroblastosis. And in much larger numbers, an increasing number of patients are being aborted in accredited hospitals on the basis of psychiatric illness.

The problem which we face today is the lack of legal permission under the present law for any of these three indications. It is an unhappy circumstance that the three indications are mentioned together in the plea of many outspoken advocates for the liberalization of the abortion laws of this state and this country. I say it is an unhappy circumstance because the two so-called "fetal" indications for abortion should not be grouped with the more nebulous "mental illness" indication. The first two mentioned causes make up a very small proportion of the therapeutic abortions in this country and, like the indications of 30 years ago, are being solved in a way that medicine should solve all its problems — by approaching the cause at its source. In reference to rubella, an official letter was issued recently from the New Jersey Department of Health announcing that there will be an effective vaccine for rubella available in 1968. As for erythroblastosis, recent work by the Columbia University Medical School[1] has led to a break-through in the fight against RH sensitization. This, with the recent brilliant work in the early diagnosis of erythroblastosis by amniocentesis and the treatment by intra-uterine transfusion, leads us to believe that men of medicine have scored two more notable victories in their constant struggle to preserve life.

The psychiatric or the mental health indication for therapeutic abortion is another matter. In many hospitals psychiatric indications make up as many as 70, even 90, per cent of the therapeutic abortions. There is a serious question as to how well these indications can be substantiated. Psychiatrists in the United States and elsewhere hold the widest possible range of opinions on this indication for abortion. Friedman[2] believes, "that no definite psychiatric criteria but the psychiatrist's personality, his school of thought, and his respect of humanitarian, socio-economic, and religious factors cover his attitudes toward therapeutic abortion."

Wolff and Caldwell[3] ask, "Are there indeed any indications for termination of pregnancies on psychiatric grounds?" Rosenberg and Silver,[4] in giving the results of a follow-up questionnaire, indicate that patients seem to manage after pregnancy, regardless of the outcome, much as they had before the pregnancy. The threat of suicide if the pregnancy is not terminated is not as frightening, since it has been reported that the incidence of suicide in pregnant women is only $\frac{1}{6}$ as high as in non-pregnant women, of comparable age, implying that pregnancy has an emotionally protective role.

It would seem with the continued decrease of medical and "fetal" indications for therapeutic abortion that the advocates of the liberalization of the abortion laws must be speaking only of the emotional, social, and economic indications. The occasional reference to the population explosion (which is not a problem in this country) is obviously much better handled by contraceptive measures. Death due to criminal abortion is occasionally mentioned as a reason for liberalizing our abortion laws. This number was grossly exaggerated in the past. As near as we can estimate now, from our improved methods of death reporting and maternal mortality studies, in this country the number of deaths from criminal abortion is probably between 400 and 500 a year.[5] Liberalizing of the abortion laws in certain foreign countries has not reduced the rate of criminal abortion.

In Denmark, where the program of liberalized abortion has been in effect for about 20 years, the criminal abortion rate has shown an increase of 77 per cent from 1940 to 1950.[6] If this is a surprise to some, it can perhaps be understood better, if one considers that the patient who received a legal abortion a year or two previously can see no reason why she should not receive a second or third abortion even though the authorities rule against it. Her decision to procure an illegal abortion can be easily understood, since there can no longer be any moral objection.

Höök[7] reported, in a series of married women having legal abortions in Sweden, that 40 per cent became pregnant again within two years. Of these, one half again obtained abortions. Ten per cent of these were illegal or criminal abortions. This recalls an experience at the Margaret Hague Hospital 25 years ago when pulmonary tuberculosis was accepted as an indication for abortion. To the surprise of the staff the same patient would return for repeated abortions, and her plea was that if the indication for abortion was valid six months ago, wasn't it still valid since she still had pulmonary tuberculosis? This complete lack of personal responsibility was a shock to the obstetrical staff who were called upon to do the abortions. This same lack of responsibility apparently became prevalent in countries where social and economic reasons for abortion prevail.

In Japan where complete freedom to have abortion on demand prevails, the abortion rate rose from 91 abortions per 1000 live births in 1949 to 700 in 1957, a situation that has caused concern in Japan because of the increasing "abortion-minded" attitude.

If abortions are readily available, personal responsibility for one's actions will decline. Legal and illegal indications for abortion will increase. Criminal abortion becomes less abhorrent, and those guilty receive punishment so light that it is no longer a deterrent to crime.

Where will we men of medicine fit into this new attitude toward life? Who will make the decisions for the physician? If there must be changes in our approach to our new problems, let them be along lines consistent with the moral values of our society. For the population control, let there be education and dissemination of contraceptive procedures. For the genetically crippled and difficult economic and social situations, again let there be contraceptive information. If this proves impractical let there be a wider use of sterilization procedures. Let the psychiatrist treat the psychiatric diseases as other medical men treat their patients, by directing the treatment at the source of the disease, with the full realization that the pregnant patient is more difficult than the non-pregnant, no matter what her illness. During the pregnancy the obstetrician will share his responsibility, and the psychiatrist can share with the obstetrician the rewards of a job well done, when the ideal obstetrical result is realized.

Let us as doctors practice in the traditional manner of seeking new ways to protect life, not in looking for more reasons for its destruction. Let us strive for the ideal in medicine where all diseases are preventable, and there is no longer a need for abortion.

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An underlying medical or surgical disorder may start with emotional symptoms which mask the basic disease and suggest a misleading psychiatric diagnosis.

Serious Medical Illness In An Acute Psychiatric Hospital

Sydnor B. Penick, M.D., and Russell N. Carrier, M.D./Belle Mead

The medical profession has become increasingly aware of the intricate relationships between medical illnesses ("organic") and psychiatric illnesses ("functional"). Nevertheless, there remains a tendency to make "functional" diagnoses by exclusion to explain symptom complexes which cannot be labeled following thorough medical work-up. This tendency leads to relaxation in diagnostic vigilance, once it has been decided that a patient's symptoms are "purely psychiatric." Yet many medical illnesses present initially with psychiatric symptoms.

Of 4032 admissions to The Carrier Clinic in the 30 month period ending in June 1966, 106 (or 2.4 per cent) were transferred to a general hospital for treatment of medical or surgical conditions. Their charts were reviewed in detail. Reasons for transfer can be classified as follows:

Class I. These cases run the gamut of medical disorders which are known to present with psychiatric symptomatology. The table summarizes patients in this category. This represents about one per cent of all admissions. As might be expected, this is heavily weighted with brain tumors. Because of this finding we recently began to do routine electroencephalograms on all admissions to The Carrier Clinic.

Class II. There were 25 patients in this category. They had medical illnesses which precipitated psychiatric difficulties. Following admission, it was found that the precipitating medical illness was more severe and that treatment would be better carried out in a general hospital. One patient was referred to The Carrier Clinic because he became agitated and unmanageable ten days following an acute myocardial infarction. His electrocardiogram was sufficiently unstable to make us feel that he should be followed in a general hospital. Following transfer, both his medical and psychiatric difficulties were easily managed and he recovered from both. A second patient became depressed and began to drink excessively four weeks following surgery for cancer of the lung. Work-up at The Carrier Clinic suggested recurrent tumor in the lung and one rib. It was felt that his psychiatric difficulties would be handled more appropriately in conjunction with study and

Medical Disorders With Psychiatric Symptomatology

Brain tumor	23
Thyrotoxicosis	3
Herpes Simplex encephalitis	2
Lupus erythematosis	2
Myxedema	2
Addison's Disease	1
Cushing's syndrome	1
Carcinomatosis	1
Hyperparathyroidism	1
Porphyria	1
Regional ileitis	1
TOTAL	38

* From the Carrier Clinic Foundation, of which Dr. Carrier is president, and to which Dr. Penick is medical consultant and director of research. This paper was, by invitation, presented in Detroit on May 12, 1967 at the Annual Meeting of the American Phychiatric Association.

treatment of his recurrent tumor in a general hospital setting.

Class III. There were 43 patients in this category. They developed medical illnesses unrelated to their psychiatric illness while hospitalized.

The following three case reports are examples of Class I patients.

Case One—Paranoid schizophrenic reaction as the presenting symptom of Cushing's syndrome.

A 32-year-old housewife, was admitted to The Carrier Clinic on July 2, 1964. The previous May 29 at a party, she insisted on going home, telling her husband that she was sure that someone was going to slip them some alcoholic beverages. This was against their religion. She concluded from a conversation heard there that their house must be wired with listening devices. The following day she began communicating with her husband by writing notes so that nobody could hear what she had to say. For the next month, she had obvious ideas of persecution, felt her children were making fun of her and that everybody knew about some secret that she was not told. Just prior to her admission, the patient armed herself with a shotgun and was planning to shoot any intruder who walked through her door. On admission, she was belligerent, hostile, obviously paranoid and had ideas of reference. Emotional reactions were inappropriate. She was alert and oriented in all spheres. She certainly knew that she was being admitted to a mental hospital. The only significant feature of her past medical history was that she was said to be hypothyroid and had been on a daily thyroid preparation. She also had not had a menstrual period since April 27. On admission, her blood pressure was 120/100. The pulse was 140 and regular. The patient's face appeared somewhat puffy. The remainder of her physical examination on admission was within normal limits. It was felt that she possibly had hypothyroidism and that she might be pregnant. The pregnancy test was negative. The patient was treated with electroshock therapy. Her hostility and belligerence gave way to a withdrawn, almost catatonic clinical picture after 20 electroconvulsive treatments. Three weeks after admission she complained of a steady ache in the left back and flank. At that time, her blood pressure was 150/75. She had tenderness in her left flank but there were no other positive findings. A gynecologic consultation was obtained and the gynecologist felt there was no possibility of pregnancy. Admission hemogram, liver function tests, and urinalysis were normal. X-rays had shown no abnormalities of her bones. A 24 hour urine for calcium was normal and 24 hour urines for keto and 17 hydroxy steroids collected six weeks after admission were reported as normal. Toward the end of her hospitalization she began to eat enormously. She gained weight rapidly. She developed striae on the trunk, which were thought to be related to the rapid weight gain. It was our opinion that (in spite of the normal 17 hydroxy steroids) she should be further worked up for possible Cushing's syndrome. She was admitted to The New York Hospital two weeks after discharge from The Carrier Clinic. At that time, she had elevated fasting blood sugar, abnormal glucose tolerance test, osteoporosis of the spine, hypertension, moon face: a full-blown Cushing's syndrome. At operation, a large unilateral adrenal adenoma was discovered and was resected. Two and a half years later this patient is entirely normal from both a medical and psychiatric standpoint. She has had no return of her psychiatric symptoms. Possibilities here include: (1) One illness—Cushing's syndrome with acute psychosis as the initial symptom; (2) Separate illnesses—an acute psychosis followed by the development of Cushing's syndrome; and (3) Cushing's syndrome precipitating a psychosis in an emotionally borderline patient. Although there is no way categorically to decide which hypothesis is correct, we favor number (1) because psychosis is a common accompaniment both of exogenous steroid therapy and of the endogenous steroid excess of Cushing's syndrome. Furthermore, the patient had no prior history of psychiatric difficulty and has been well since her definitive therapy.

Case Two—Thyrotoxicosis diagnosed as agitated depression.

A 51-year-old man was admitted to The Carrier Clinic with a diagnosis of agitated depression. He had become tremulous and "nervous" six months prior to admission. This occurred in a setting of changes in management and personnel at his place of work. He had been promoted to foreman and began to worry about being able to handle his new job. He was seen hy the company physician at the time and examination was said to be nomal. A psychiatrist treated him for the following six months. During this time he became increasingly tremulous. He was unable to hold a cup of coffee by himself without spilling it. He had marked trouble in sleeping and lost 60 pounds even though he was eating more than he ever had before. Because of increasing deterioration and failure to respond to psychotherapy or chemotherapy, he was referred to The Carrier Clinic. On admission, his blood pressure was 160/80. Pulse was 160 to 180 and grossly irregular. He was very "nervous" and tremulous. There was a slight stare, but no lid lag. The thyroid gland was diffusely enlarged; no nodules were felt. The heart was beating at an extremely rapid rate, with a grossly irregular rhythm. The left ventricle appeared to be enlarged. Lungs were clear. Examination of the abdomen was negative. Extremities were warm and moist and there was a gross tremor of the outstretched fingers. Electrocardiogram showed rapid atrial fibrillation with multiple premature ventricular contractions. Admission laboratory work revealed a hematocrit of 36 per cent, a white cell count of 5,000 with a normal differential count. Alkaline phosphatase was 14 units, transaminase was normal, bilirubin was 0.65, thymol turbidity 2.3 units, and fasting blood sugar was 61. Urinalysis revealed some acetone but was otherwise negative. Serum cholesterol was 200. Basal metabolic rate was plus 90. Protein bound iodine the day of admission was 17.8 micrograms (normal is 4 to 8), Triiodothyronine red cell uptake was 0.73 (normal is 0.9 to 1.1). Subsequently, an RAI uptake was 95 per cent in 24 hours. Since he had classic Grave's disease, he was transferred to a general hospital. He was digitalized, placed on reserpine and responded very well. At a subsequent date he was treated with radioactive iodine and as of April 1967 had regained all 60 pounds in weight, felt well, had no psychiatric symptoms and was functioning nicely as a foreman. We all know that Grave's disease may occur during periods of emotional stress and, therefore, there is a possibility that his initial symptoms were due to anxiety which then precipitated his thyrotoxicosis. Or, perhaps his entire illness was ex-

plained on the basis of thyrotoxicosis. In either case, the deteriorating clinical picture with tremor, weight loss, and anxiety should have suggested the diagnosis earlier. An important clue was weight loss with increased food intake, which is a distinct feature of thyrotoxicosis.

Case Three—Involutional psychotic reaction with a regional ileitis.

A 51-year-old married woman had been somewhat depressed for a year and a half prior to admission. She had complained episodically of abdominal pain during this time. In the week prior to admission, the complaints of abdominal pain increased. During the seven days prior to admission she had been unable to keep anything down, vomiting everything that she took by mouth. The day prior to admission she asked her son to shoot her because of the pain in her abdomen. For this reason she was felt to be suicidal and was referred to The Carrier Clinic. On admission, she seemed to be in considerable pain. The abdomen was distended. The examining psychiatrist thought that she might have an intestinal obstruction. For this reason, she was transferred to a general hospital. She had fever and the abdomen was distended and rigid. Bowel sounds were absent. She was immediately taken to surgery because of suspected perforated viscus. At the time of transfer to the general hospital, systolic blood pressure was 70 by palpation. Pulse was 144. At operation, long-standing, severe (and previously unsuspected) regional ileitis was discovered with recent perforation and generalized peritonitis. A bypass operation was done. After a stormy medical course, the patient recovered. She has been seen at intervals in the office since that time. She has regained all the weight that she had lost. She is cheerful, eating and sleeping well, and, according to her family, better than she has been for three years. This woman must have been suffering from regional ileitis for some time but her complaints of abdominal pain were not adequately worked up. One must always keep in mind that a chronic, painful, debilitating illness produces psychiatric symptoms. These may indeed be secondary, but intermittent abdominal pain and anorexia over a period of two years could certainly be a most depressing experience.

Summary

Review of the record of The Carrier Clinic (an acute mental hospital) over a period of 18 months reveals that 2.4 per cent of the admissions required transfer to a general hospital for treatment of medical or surgical conditions. Many of these are instances of coexistence of medical or surgical disorders with psychiatric illnesses. Here, treatment of the medical or surgical illness took precedence over treatment of the emotional disorder. However, in a significant number of cases (such as the three cases reported above) psychiatric symptoms for which the patient was referred for treatment were found to be associated with recognized medical syndromes. These occurred in patients, who, as far as could be determined in follow-up, had no significant psychiatric illness.

In treating psychiatric patients, one must always keep this in mind. Constant and meticulous reevaluation of the physical condition is mandatory. This is particularly important in view of some data[1] suggesting that persons with psychiatric illnesses indeed develop medical illnesses more frequently than others. The problem often arises from the separation (in the minds of both the medical profession and the public) of emotional from medical disease. It arises when patients with psychiatric symptoms are "worked up" medically and nothing is found. The patients' complaints are then, by exclusion, thought to be "functional" and they are referred for psychiatric care.

A plea is here made for continuing awareness that psychiatric patients may have treatable physical illnesses, which may in some cases largely explain their psychiatric symptoms. The emotional symptoms may appear before recognizable medical syndromes do. The importance of a careful medical history and physical examination in "acute psychiatric" patients, both at initial contact and during the course of treatment, cannot be overemphasized.

[1] Hinkle, L. E. and Whitney, L. H.: *Journal of Occupational Medicine,* 3:9 (September 1961)

The Carrier Clinic

Inadequate antibiotic therapy in upper respiratory infection may lead to an empyema, which will respond best to thoracotomy and decortication.

Empyema Thoracis

Franklyn P. Gerard, M.D., Adrian M. Sabety, M.D., John S. Madaras, Jr., M.D., and Silverio Ceniza, M.D./East Orange

One of the oldest thoracic diseases, empyema thoracis, continues to plague the profession. With the availability of antibiotics, the incidence of empyema has certainly decreased. However, a false sense of security causes many of us to ignore the possibility that empyema can still be a complication to a "severe cold" that fails to respond to therapy. Our attention has been called to this by an increasing number of cases of empyema which have followed delayed or inadequate therapy. Furthermore, a small number of patients will develop empyema despite what appears to be adequate therapy.

A series of nine patients with empyema thoracis has been treated with open thoracotomy and decoratication. Of this group, six were males. Ages ranged from 42 to 73 years (we are not including infants and children with empyema secondary to staphylococcus *aureus* pneumonia). The right chest was involved in six cases.

Symptoms included malaise, chest pain, sweats, dyspnea, temperature elevation, and non-productive cough. Duration of these symptoms varied from one to eight weeks. Thoracentesis carried out before thoracotomy revealed yellow, cloudy fluid and in some instances, thick yellow pus. The culture revealed coagulase positive staphylococcus aureus (four cases), hemolytic streptococci (one case), and sterile culture in the remaining cases.

All nine patients were treated with open thoracotomy and decortication. In all cases, patients were discharged in less than fourteen days following surgery – with one exception. The latter, because of general debility, required three months of hospitalization.

Analysis of these cases clearly shows the same pattern:

1. Upper respiratory infection treated with antibiotics inadequately or too late in the course of the illness.
2. Inadequate follow-up due, in great part, to the patient's failure to return to the treating physician.
3. Masked temperature curve due to antibiotics.
4. Elevated sedimentation rate and leucocytosis in the face of normal temperature, which is indicative of underlying infection.
5. Tired, weak, easily fatigued patient.
6. Chest X-ray showing fluid or a bizarre pleural reaction.

The treatment in our opinion is open thoracotomy and decortication where possible to allow the "trapped" lung to expand and fill the dead space. On occasion, the therapy may have to be limited merely to drainage due to the debilitated state of the patient. In these cases, one must prepare the patient psychologically for the prolonged period of tube drainage that will follow.

Conclusion

To avoid this thoracic complication, we strongly recommend an adequate period of antibiotic therapy as opposed to the "occasional shot" or sporadic course of broad spectrum antibiotics. Frequent follow-up chest X-rays, as the patient's general condition dictates, may help prevent the situation from advancing beyond the level of therapy. In any event, the X-ray will alert the physician to an incipient major thoracic problem.

144 South Harrison Street

Increasing interest in the emotional aspects of schooling has led to the wider use of psychiatric consultants in the public schools. As Dr. Markowitz here points out, this is not entirely without some booby traps along the way.

Some Difficulties Of Psychiatric Consultation To School Personnel

Irving Markowitz, M.D./East Orange*

Increasingly, the psychiatrist is being encouraged to venture forth from the comparative comfort of the eight-patient day into the blackboard jungle. Less enthusiastically acclaimed is the concept that the educator should become more actively involved in the treatment of emotional problems. This has not been a role that the educator has been cheerfully willing to assume nor one the psychotherapist has been overly eager to assign to him.

If, however, the many emotionally disturbed youngsters not ordinarily seen in clinics are to receive help, it is the educator more than anyone else to whom the therapist must turn. To encourage help from educators, we cannot urge them to apply their perceptions and understanding to students' problems and at the same time constantly warn them of the dangers of going beyond their depth. Poor collaboration between teacher and therapist may often be traced to the unwillingness of the therapist to pass the baton to anyone of different background from his own. Often, too, consultants propose to educators procedures appropriate only to clinical settings. Such transplants wither and die in soil never intended for their growth.

If, instead, the resources of the school, sometimes greater than those of the clinic, are used to best advantage, results can be achieved that might not have been achieved by clinical methods of operation. One teacher, as a result of school consultation, came to see her own role in accentuating a pupil's difficulties and was able to relate to this child differently so that his behavior and grades improved markedly. A school social worker, completely inexperienced in group therapy, arranged within the school day to work with a group of eight delinquent youngsters, all of whom were failing and about to be expelled from the high school. She managed, in the course of two years' work with them, to so improve their functioning that all of them earned their diplomas. Whatever the degree of profundity a clinic may attain, it is doubtful that any clinic would have had so high a percentage of social success.

The joys to be found in collaborative endeavor between educator and therapist may lead to minimization of the many difficulties. Two different approaches to school consultation and the problems encountered in their use are here discussed briefly.

The first approach was an outgrowth of periodic meetings with the psychological services of the six different school systems served by a clinic. It was agreed that free consultation would be offered any school system seeking it. It was stipulated, however, that *the consultant would not have any direct contact with the child.* The thought was that this would in-

* Dr. Markowitz is director of the Child Guidance Clinic of the Oranges.

dicate that the consultant did not intend to take over complete responsibility for definitive solution of the problem. The educator could not then easily leave the pupil on the doorstep of the clinic waiting list and would, perhaps, develop greater regard for his own resources. Occasionally, out of the meager information presented in any one session, suggestions were made which when applied by the educator or guidance counselor resulted in unexpected, happy solutions. Just as often, however, school consultation led to mutual commiseration about the many barriers in the home, school, clinic, and community that prevented both educator and clinician from doing better jobs. Such commiseration led, at times, to greater complacency and smugness on the part of the educator as he realized that the consultant's magic was no greater than his own; sometimes to competitive vigor on the part of the educator to prove the consultant wrong; but also, more gratifyingly, to greater mutual endeavor to do what could be done rather than make excuses for failure.

The second approach emerged when a small metropolitan city hired the consultant to evaluate the work of the child study team and to work out principles of better collaboration between the team and the school administration. Prior to this, the school system had decided to use outside psychiatrists of differing orientations to work with groups of principals on the basis of there being so many problems in the school that resources would be better used by working on the emotional problems of the staff than on the emotional problems of the children. Those psychiatrists and analysts who were able to relate to the staff only in the same way that they related to their patients were the ones rated by the teachers, principals, and child study team as the least successful. The teachers were willing to accord the consultant the possibility of a different perspective, but not a perspective beyond their attainment.

Poor communication between therapist and educator is frequently the result of fundamental differences in viewpoint. Therapists generally feel that all passion is to be encouraged while educators tend to feel that all passion should be subdued. Therapists generally feel that the system should be adapted to the individual while educators, in spite of the tenets of progressive education, feel that the individual should adjust to the system. When they do accept individualism, educators tend to be more partial to the non-troublesome than to the troubled, while therapists tend to the opposite bias.

These differences were starkly apparent in a vocational school where the consultant had volunteered to go as part of a project of working with groups in the school consisting of the administrators, guidance personnel, clerical staff, and nurse. The faculty was proud that its standards of performance were higher than those of the academic high schools in the school system. They had had friendly relationships with the child study team and were eager to have the team come to their school to help remove the psychologic kinks in their product.

The consultant pointed out—with the trend in our society being to relegate non-college oriented students to second class status—that by making their students work harder for lesser rewards, they might be fostering increasing rivalry between craftsman and scholar. A question was also raised about the inadequate consideration given the identity-defining problems of a Negro cosmetology student selected for token desegregation. The conference then shifted to a discussion of truancy, illness, under and over-archievement, and ended on a note of concord and friendliness. The child study team psychologist commented to the consultant later, "For a while there, I thought you were really going to queer it. Why raise a fuss, if you don't expect change?"

Whatever part the personal needs of the consultant—to refuse to submit without protest—played in this discussion, it is nonetheless valid that the effective consultant should not relinquish all possibility of growth to gain harmony.

Teachers are more frequently females and consultants more frequently males. Women who have found in conformity a route to freedom and significance are more likely to treasure conformity than men who have historically found it a barrier to their exercise of privilege. The rebelliousness of the male consultant may make communication difficult with the female teachers. The consultant may choose to appear conforming in order to achieve false harmony. Such harmony exists only in so long as each caters to the other's prejudices. Real harmony is the willingness of consultant and educator to grapple with each other's concepts rather than to seek for immediate reconciliation of differences.

A recurring theme in school consultation has been the question of how much do the structures of our society cater to the needs of the handicapped. How long does the school bus wait for the straggler? The horse and buggy could afford to wait longer for the late-comer than the airplane and both have waited longer for the important person than the ordinary one. Numerous discussions of this question have persuaded some schools to modify many of their fixed patterns to allow for different individual needs.

Along with the dissimilarities, there are also similarities of viewpoint which may impair adequate consideration of the pupil's needs. Teacher and educator often prefer to believe that resistance to help or enlightenment is ingrained in the pupil or patient rather than the result of tyranny. Teachers, too, tend to believe along with (and more than) therapists, that intimate involvement with the individual hinders objective understanding; that detachment is necessary to perspective. Another view often shared by teachers and therapists is that permissiveness is in and of itself non-authoritarian; where often the truth is, that the psychiatrist or teacher who can brook every insult may be as or more authoritarian than the paranoid individual who can brook none. In the mutual flattery of easy agreement, both teacher and consultant may be lulled into complacency and inaction.

School consultation has often fallen into patterns of Socratic irony. Many new approaches need to be explored if consultation is to become more useful. One psychologist sat a first grade teacher in the midst of her pupils. He then offered his hand to one of the pupils and dropped it quickly when the pupil approached. When the pupils were questioned about their feelings, both psychologist and teacher were surprised at the speed with which the youngsters extrapolated from this to their relationships with the teacher. They spoke feelingly of the many situations in which she had built their expectations of what she would do for them if they performed well, and of how often she had, for a variety of seemingly logical reasons, postponed their rewards. This and similar approaches to school consultation seem much more promising than learned lectures on the double bind.

The welcome mat is out for those analysts who choose to become school consultants. If, however, psychiatrists are to savor the sparkle and excitement of their return to the classroom, they need to be heedful of the booby traps under the mat.

115 South Munn Avenue

1968 Annual Meeting

Saturday, Sunday, Monday, Tuesday, Wednesday — May 18-22, 1968

Haddon Hall, Atlantic City

STATE ACTIVITIES

Trustees' Minutes

October 15, 1967

A regular meeting of the Board of Trustees was held on October 15, 1967, at the Notre Dame High School in Trenton. A summary of the significant actions follows. More detailed minutes are on file with the Secretary of your component society.

AMA Conference on Health Care for the Poor . . . Empowered the Chairman of the Board and the President to designate representation to the AMA Conference on Health Care for the Poor, to be held in Chicago on December 15 and 16. (Subsequently Dr. Nicholas E. Marchione, Chairman of the Council on Medical Services was named.)

Health Facilities Planning Council . . . Directed that the name of Dr. Jesse McCall of Newton be submitted for renomination to membership on the board of trustees of the Health Facilities Planning Council.

Board of Medical Examiners . . . Announced that the Governor had reappointed the following, each for a three-year term, to the Board of Medical Examiners:

Edwin H. Albano, M.D., East Orange
Thomas C. DeCecio, M.D., Cliffside Park
Lloyd A. Hamilton, M.D., Lambertville
Jerome G. Kaufman, M.D., Maplewood
John J. McGuire, M.D., Newark

Anthony J. Balsamo, M.D., Jersey City, was appointed in April to fill the vacancy created by the death of Vincent P. Butler, M.D. The vacancies created by the deaths of Daniel F. Featherston, M.D. and F. Clyde Bowers, M.D. have not yet been filled.

Medical Defense and Insurance . . . Approved a recommendation of the Committee on Medical Defense and Insurance that representatives of the Board of Trustees meet the Committee to confer with representatives of the American Mutual Liability Insurance Company to discuss requested premium levels and coverage.

. . . Directed that an invitation to this November 12th meeting be extended to the chairmen of the insurance committees of all county societies.

Loss Control Program (American Mutual Liability) . . . Approved the revised directive of the functions of the Medical Defense and Insurance Committee and the Medical Review and Advisory Committees of the County Societies in the American Mutual Liability Company's Loss Control Program for distribution to the component societies.

Liability in Hospital Emergency Room Service . . . Approved a recommendation of the Medical Defense and Insurance Committee that a letter from the American Mutual Insurance Company concerning liability insurance coverage for emergency services provided by groups of physicians in hospitals be brought to the attention of the component societies and the staff of each New Jersey hospital, and that the information be reflected in THE JOURNAL. (See page 662 this issue)

Tuberculosis — Preventive Therapy . . . Endorsed a program being developed by the Department of Health in the area of "preventive therapy of tuberculosis," and requested that MSNJ's support of such program be evidenced by an article in THE JOURNAL, or the publication of a series of articles prepared by the Department.

Emergency Medical Care . . . Approved the following recommendations of the Special Committee on Emergency Medical Care:

1. That the State Department of Defense, Civil Defense Division, retain control over the units of the First Aid Medical Posts.

2. That the Department continue its annual inspection of the units and report its findings to the MSNJ Committee on Emergency Medical Care.

3. That, when the number of patients reaches a level beyond the ordinary capacity, consideration be given to inauguration of the hospital's disaster plan and other emergency procedures. Concentration of casualties in any one hospital should be avoided.

4. That the training program for ambulance attendants should include anatomy; physiology; restoration of the airway; control of hemorrhage; dressing of wounds; splinting of fractures; treatment of shock; transportation of the injured; child birth; cardiopulmonary resuscitation; and abdominal, chest, and external injuries.

5. That component societies urge their hospitals to establish some agreement in advance that will (prior to arrival of casualties in a hospital emergency room) give all details concerning the extent and nature of the disaster and the type and number of victims on the way.

In connection with #4 above, the Board reaffirmed its action of March 19, 1967, and directed that this be brought to the attention of the component societies.

Audit Review . . . Approved the report of the special committee to review the 1966-67 audit.

Institute on Long-Term Planning . . . Empowered the Chairman to designate a representative from MSNJ to attend the Health Facilities Planning Council Institute, November 29th in Princeton. (Subsequently Dr. Louis F. Albright of Spring Lake was named.)

25th Anniversary of Medical-Surgical Plan . . . Directed that the President of MSNJ, at the forthcoming anniversary dinner of MSP, present an official message of congratulations to the Plan, and that an appropriate commemorative plaque be prepared and presented to Plan officials at the 1968 annual meeting of MSNJ.

Medical Practice Act . . . Directed that an official request be made of the State Board of Medical Examiners to call upon the Attorney General to make a complete, current version of the Medical Practice Act available to MSNJ.

Conference of County Society Presidents . . . Received the report of the Chairman of the 6th Conference of Presidents of Component Societies which included discussion of the following subjects: chiropractors and the medical practice act; osteopathic physicians; abortion laws in New Jersey; "Community Health Week"; AMA releases *re* lowest priced drugstores for prescription items; nursing homes; implementation of Title XIX; notices of meetings in Trenton to be sent to County Societies; comprehensive neighborhood health services' programs; action of Trustees concerning utilization committees (proposed draft of bill); and fees for welfare patients.

More About Smoking

The federal government has stepped up its campaign against cigarette smoking with the issuance of a new report and the appointment of a Lung Cancer Task Force. A second Public Health Service report summarizes three and one-half years of research into the health dangers of smoking. The Department of Health, Education, and Welfare said the current study strengthens the conclusions of the 1964 report. The second research provides new technical data on the relationship of smoking to cardiovascular disease, chronic bronchopulmonary disease, cancer, and other conditions.

Cigarette smokers have substantially higher rates of death and disability than their nonsmoking counterparts in the same population.

If it were not for cigarette smoking, practically none of the earlier deaths from lung cancer would have occurred; nor a substantial portion of the earlier deaths from chronic bronchopulmonary diseases; nor a portion of the earlier deaths of cardiovascular origin. Excess disability from chronic pulmonary and cardiovascular diseases would also be less.

Cessation or appreciable reduction of cigarette smoking could delay or avert a substantial portion of deaths which occur from lung cancer, a substantial portion of the earlier deaths and excess disability from chronic bronchopulmonary diseases, and a portion of the earlier deaths and excess disability of cardiovascular origin.

Our State Health Department Reports

The following communicable diseases were reported to our State's Division of Preventable Diseases during September.

	September 1967	*September 1966*
Aseptic Meningitis	29	32
Encephalitis, primary	1	* 7
Encephalitis, post-infectious	1	5
Hepatitis — Total	127	134
Infectious & unknown	108	111
Serum	19	23
Malaria (servicemen)	18	*<1
Meningococcal Meningitis	2	* 11
Rocky Mountain Spotted Fever	8	* 11
Primary Syphilis	24	* 55
Salmonella	26	102
Shigella	12	7

The following viruses have been isolated from cases of aseptic meningitis: Coxsackie B5, Echovirus 14 and mumps. Outbreaks of Coxsackie B5 had been reported during August and September from Baltimore and from Ohio.

One human and eleven horse deaths were due to Eastern Equine Encephalitis in September 1967. All were in southern New Jersey. This has been the second confirmed human case of Eastern Equine Encephalitis since the outbreak of 1959. The New Jersey State Department of Health is actively studying the ecology of Eastern Equine Encephalitis. The virus has been isolated from the mosquito *aedes sollicitans,* the common salt marsh mosquito.

An increase in the incidence of malaria has been ascribed to returns from Viet Nam. In the U.S.A., up to September 30, 1967, a total of 1,486 cases of malaria have been reported, compared with only 308 cases at this same time last year.

A southern New Jersey family of six was tested for Rocky Mountain spotted fever after four members were clinically diagnosed as having developed the disease within a three week period. The pet dog was shown to have been exposed to the disease. There is a history of a heavy tick infestation on the dog and in the house. Ticks were collected and identified as the usual species (*dermacetor veriables*) associated in this area of the country with this disease. Twenty cases of Rocky Mountain spotted fever have been reported in New Jersey residents so far this year. But due to the difficulty of making a clinical diagnosis, this disease is almost certainly underreported. Our State laboratories do a specific complement fixation test for Rocky Mountain spotted fever.

The New Jersey Department of Health maintains surveillance on *all* communicable diseases. A list of these diseases can be found in Chapter II of the State Sanitary Code. Physicians report diseases either to their local health officer or to the Division of Preventable Diseases of the State Health Department.

Through the "Vaccination Assistance Program," the Division of Preventable diseases is participating in the national measles eradication program. Vaccine is available through the State distribution center where physicians may obtain vaccine free of charge for those patients who need be spared the cost. The "Vaccination Assistance Program" is interested in all requests for assistance in local immunization programs. Last year 37,000 doses of Schwarz measles vaccine were distributed through such programs, and 120,000 doses were distributed through other state sources. It is hoped that the incidence of measles will be so low that the Division of Preventable diseases will be able to investigate the epidemiology of each case and to follow-up with specific immunization programs if necessary.

Hepatitis

Within the past year the Division of Preventable Diseases has become more interested in the association of parenteral drugs and serum hepatitis. Presently cases of hepatitis are checked against lists of known narcotics addicts in the major cities of the state. Surveillance is carried out on blood donors who become associated with a case of serum hepatitis.

* This figure is approximated for the total number of cases reported in 1966.

The following report appeared in *Morbidity and Mortality* of May 27, 1967. It describes an outbreak of narcotic-associated hepatitis in Morris County, New Jersey.

"An outbreak of 14 cases of viral hepatitis occurred among a group of 57 known or suspected narcotics addicts in one New Jersey county between September 1966 and May 1967. Of these, 12 were concentrated during February, March, and April 1967. Fifty-five of the 57 addicts were male; their ages ranged from 17 to 36 years; 49 were between 18 and 24 years old.

"Eight of the 14 cases were hospitalized with jaundice; two had a history of jaundice and four the anicteric form of the illness. All of the 14 patients were known to have shared injection equipment with at least one person who either had been ill with hepatitis or subsequently developed the disease. There was such extensive sharing among different addicts and repeated use by individual addicts that valid incubation periods could not be determined.

"A single serum specimen was collected during the week of April 24 from 55 of the 57 addicts in the group. Serum glutamic pyruvic transaminase (SGPT) values are shown in Table 1. Forty-three had no history of illness or jaundice in the preceding six months, but 29 (67 per cent) had SGPT values about 40, well above normal levels. Moreover, 12 values were above 100.

"Table 2 examines the serum transaminase results among the 43 non-ill addicts according to the history of having shared narcotics equipment with at least one of the addicts with hepatitis, 21 of whom did not admit sharing. Of the former group, 19 90 per cent) had values above 40. Thus, the sharing of injection equipment with an addict who had hepatitis was associated with a greater frequency of elevated SGPT values."

Table 1

SGPT Values Among 57 Addicts

SGPT Values	Addict Group: History of Compatible Illness/ Jaundiced Hospitalized	Jaundice Not Documented Jaundiced	Illness/ Not Jaundiced	No Illness or Jaundice
Not done	2	—	—	—
0-29	2	2	3	12
30-39	—	—	1	2
40-49	3	—	—	17
100-299	1	—	—	6
300+	—	—	—	6
Total	8	2	4	43

A follow up survey was undertaken in the beginning of October and 37 of the original group were interviewed and blood for SGPT's was drawn. There were 13 new cases, i.e. in addition to the original 14. During the month of October a small outbreak of hepatitis was studied in Cape May County. The disease was confined to one group of families who were linked closely by intermarriage, location, and occupation. Among the members of these families, the incidence of icteric and anicteric hepatitis was 50 per cent. The common source of infection was felt to be a contaminated well. The original source causing the contamination of the well is felt to be associated with raw clams.

Table 2

SGPT Values Among 43 Addicts with no History of Jaundice or Compatible Illness

	Less than 40 SGPT	More than 40 SGPT	Total
Persons who admitted sharing with addict who had hepatitis	3	19	22
Persons who did not admit sharing with addict who had hepatitis	11	10	21
Total	14	29	43

Measles

Of the 20 cases of measles reported to the Department, the majority are from Newark. On follow-up inquiry many of these cases have been found to be German measles or skin rashes of other causes.

Hospital Infections

A program on Hospital Infections control will be held on January 25. All hospital administrators will receive a brochure on the meeting. The Division of Preventable Diseases has personnel capable in assisting hospitals establish infection control programs.

Communicable Disease Statistics October 1967

	October 1967	October 1966
Aseptic Meningitis	29	12
Encephalitis, primary	0	4
Encephalitis, post-infectious	0	3
Hepatitis-Total	125	128
Infectious & unknown	109	111
Serum	16	*17
Malaria (servicemen)	13	* 1
Meningococcal Meningitis	5	*11
Rocky Mountan Spotted Fever	0	* 1
Primary & Secondary Syhpilis	52	*55
Salmonella	47	51
Shigella	17	* 7
Leprosy	1	0
Measles	20	*40

* This figure is approximated.

The Board Of Abdominal Surgery

The American Board of Abdominal Surgery is not recognized by the federation of medical specialty examining boards. The AMA House of Delegates at the 1967 convention adopted Resolution 123 as follows:

Resolved, That the House of Delegates takes cognizance of the recent actions of the American Board of Abdominal Surgery, which Board is *not* approved by the AMA, and has acted in defiance of previous actions of the House of Delegates; and be it further

Resolved, That the House of Delegates decries and condemns such practices; and be it further

Resolved, That the American Medical Association make known its disapproval of unapproved Boards unethically using the name "American Board" in its title, thereby misleading the public and the profession.

It was not clear whether this implied that the officers and diplomates of the Board of Abdominal Surgery were considered, *ipso facto* unethical. By a recent Judicial Council ruling, it appears that they are *not* to be considered unethical. In this connection, the AMA Judicial Council has authorized the following release.

The Judicial Council of the American Medical Association has found that the resolution on unapproved specialty boards adopted by the House of Delegates at the 1967 Annual Convention was not based upon evidence of unethical conduct.

The Council considered the matter at the request of the American Board of Abdominal Surgery and the American Society of Abdominal Surgeons, charging that Resolution 123 as amended and adopted "constitutes an unwarranted and improper censure" of the AMA members who are also members of the two organizations.

The AMA Judicial Council does have jurisdiction to determine the issues involved, and finds that Resolution 123 "should not be construed or interpreted as a determination of any violation of the Constitution and Bylaws or the Principles of Medical Ethics of the American Medical Association on the part of the petitioners or those members of the AMA who are similarly involved." The Council then added that, "within the frame of reference of Resolution 123 as adopted by the House of Delegates, the testimony given at the hearing disclosed no evidence which would establish that the petitioners or members of the American Board of Abdominal Surgery and the American Society of Abdominal Surgeons have acted in violation of the Constitution and Bylaws or the Principles of Medical Ethics of the American Medical Association."

Blaise Alfano, M.D., secretary of the American Board of Abdominal Surgery commented that he was pleased with the decision, and said this clears up the controversy.

Edward J. Krol, M.D., Chicago, chairman of the Abdominal Surgeons' group, commented: "I think the American Board of Abdominal Surgery and the Society have been vindicated by this action of the Judical Council. I am encouraged by this demonstration that we have a real democracy in the AMA."

Insurance For Emergency Room Groups

Following is a letter from the American Mutual Insurance Company to the Chairman of our Committee on Medical Defense and Insurance:

Dear Doctor Mettler:

New Jersey is following the trend of other states where hospitals are arranging for coverage of their emergency services by a group of doctors. In some instances, these activities are covered by an insurance policy secured by the hospital. In other instances, partnerships or corporations are being formed.

Information should be made available to all doctors in New Jersey that, when they participate in a formal or loose organization for this purpose, they are subject to liability, not only as a result of their individual acts but also as members of a partnership or corporation. Such liability would *not* be covered for Indemnity or Defense under our policy of

insurance and I believe that no other insurance company would give such protection. It would be necessary to secure a policy for the partnership or corporation.

The American Mutual has finally agreed to afford this coverage for any group, if we insure 50% or more of the members of the group for individual acts coverage under our program. If all members of the group are insured under our program, we will use the same rules for partnership cost whether it is a partnership or corporation, and the cost is 5% of the individual cost for professional acts coverage. However, if we do not insure all members of the group, there will be a different rating procedure which will be more expensive; and each group would have to be separately rated.

Sincerely yours,
J. A. BRITTON
General Manager
Professional Liability Division

Physicians Serving As Impartial Experts

At its September meeting, the Board of Trustees directed a reminder to all doctors serving on the impartial medical or professional liability panel. Certainly such membership is an honor, but it is not, in any way, a certification of the doctor's qualifications, and physicians should not cite the appointment as if it were. Our legal counsel has called attention to the following notice from the Administrative Director of the Courts:

The cases of *Zenson v. D'Elia,* 94 *N.J. Super.* 164 (*App. Div.* 1967) and *Mazza v. Winters,* 95 *N.J. Super.* 71 (*App. Div.* 1967) make it clear that the appointment of a physician under 4:25A (impartial medical experts) "was not intended to add generally to the qualifications of the expert in the sense that a medical degree might — nor do we think it intended that as the expert's qualifications are weighed by a jury there should be placed in the scales the prestige of the Supreme Court, which promulgated the rule. For these reasons we hold to be improper the showing of appointment to the panel, at least in a case in which he is not called to testify as an impartial witness in accordance with the rule of court."

The reasoning of these cases clearly applies to physicians appointed to panels to hear professional liability claims against members of the medical profession under Rule 4:25B.

The Supreme Court appreciates efforts by the Medical Society in serving "the common interest of the public." Rule 5:25B, like Rule 4:25A, was not intended to add to a physician's qualifications as an expert nor to be construed as a certification by the Supreme Court as to his qualifications. It is, therefore, improper and embarrassing to the physician involved for an attorney to refer to such appointment in the presence of the jury except in those cases in which the physician is called to testify in his capacity as an impartial medical expert in accordance with Rule 4:25A-10.

Honory Degree To Dr. Apgar

The New Jersey College of Medicine and Dentistry has bestowed an honorary Doctor of Science degree to a life-long New Jersey physician, Dr. Virginia Apgar, creator of the "Apgar Score."

The "Apgar Score" is a clinical evaluation developed by Dr. Apgar which is made within 60 seconds after birth to determine the baby's overall condition by appraising heart rate, muscle tone, respiration, reflexes, and color. The information has demonstrated its value in making a prognosis of the baby's chances for survival, in detecting masked abnormalities and in alerting physicians to the need for emergency procedures. The test has become standard procedure in hospitals in many countries.

Dr. Apgar is director of the basic research department of the National Foundation (March of Dimes). She has had service as a professor of anesthesiology at Columbia University College of Physicians and Surgeons. She was the first woman to hold a full professorship at that institution.

Dr. Apgar has assisted in the delivery of more than 17,000 infants while holding the posts of attending anesthesiologist at Presbyterian Hospital, New York City, consulting anesthesiologist at Valley Hospital, Ridgewood, New Jersey, and at Goldwater Memorial and Triborough Hospitals in New York City.

The author of more than 60 medical publications, Dr. Apgar is a widely-known lecturer in the United States, Canada, England, Australia, and New Zealand. In 1965, she was appointed Lecturer in Pediatrics, the first appointment in the nation to include birth defects as a subspecialty, at Cornell University Medical College. She was named Woman of the Year by the Federation of Women's Clubs of Westchester County in 1967.

Born in Westfield, New Jersey, Dr. Apgar graduated from Mt. Holyoke College and received her medical training at Columbia University College of Physicians and Surgeons. She holds a master's degree in public health from The Johns Hopkins University. Dr. Apgar lives in Tenafly.

In awarding the honorary degree, Dr. Robert R. Cadmus, president of the college, said, "You have combined mastery of your medical specialty with warm compassion and that gift for organization and propaganda which De Tocqueville described as characteristic of American womanhood, and have made passage from the womb into the light of day less hazardous. The Apgar Score — like gender — is now indelibly observed and recorded."

Pharmaceutical Manufacturers' Code

A comprehensive code covering the advertising and promotion of prescription drug products was announced in September 1967 by the Pharmaceutical Manufacturers Association. Mr. Joseph Stetler, president of the Association termed the code "a clear demonstration of the industry's good faith and determination to safeguard the high standards of drug advertising and promotion." To assure compliance with federal laws, the code was submitted in advance to the Department of Justice for study. Final clearance from that Department was obtained on September 18, 1967.

The code is an outgrowth of the industry's recognition of "the importance to the public health" of providing the medical profession with accurate information on drug products, "and the need to assure that PMA members, their employes, and agents present such information fairly and objectively." It covers advertising and promotional communications, including journal advertising, mailing pieces, films, exhibits, and other visual presentations. Also covered are written instructions and materials prepared for sales or professional representatives. Calling for "complete and accurate" information for marketed prescription drug products, the code states that claims should "not be stronger" than substantial scientific evidence "or other responsible medical opinion warrants." "Every effort," notes the code, "should be made to avoid ambiguity," and it calls for "a valid scientific basis" when comparing drug products.

While the code prohibits premature public communications on new drugs, it clearly states no intention to restrict "a full and proper exchange of scientific information . . . including appropriate dissemination of investigational findings in scientific or lay communications media."

The code declares that any member firm "which clearly and persistently violates the Code may be asked to resign from the Association." Under the formal title of the "PMA Code of Fair Practices in the Promotion of Drug Products," the code replaces an earlier set of principles which has covered ethical drug promotion practices since 1958. PMA is a non-profit, scientific, professional, and trade organization representing the manufacturers of more than 95% of the nation's prescription drug products.

Here is the text of the code:

PHARMACEUTICAL MANUFACTURERS ASSOCIATION CODE OF FAIR PRACTICES

September, 1967

Recognizing the importance to the public health of providing the medical profession with accurate information on drug products, and the need to assure that PMA members, their employees, and agents present such information fairly and objectively,

The Pharmaceutical Manufacturers Association hereby promulgates and adopts the following Code of Fair Practices in the Promotion of Drug Products as a revision of its 1958 statement of Principles on the same subject:

A. Code Standards

1. As used in this code:
(a) The term "drug product" means any pharmaceutical or biological product intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in humans, or to affect the structure or any function of the human body, which is promoted and advertised to the medical profession rather than directly to the lay public.

(b) The term "promotional communications" means (1) journal advertising, mailing pieces, and similar written materials (including, to the extent reasonably practicable, films, exhibits, and similar visual presentations) directed to members of the medical profession by the pharmaceutical industry for the purpose of promoting a drug product and (2) written instructions and materials prepared for sales or professional representatives containing representations to be made by them to members of the medical profession. Where compliance with the requirements of this Code is not reasonably practicable within the format of a film, exhibit or similar visual presentation, written materials meeting those requirements shall be distributed to all members of the medical profession attending the presentation.

(c) The term "medical profession" includes allied professions in the health field.

2. Complete and accurate information concerning marketed drug products should be made available promptly to the medical profession. Promotional communications to the medical profession which include a description of indicated uses or dosage recommendations for a prescription drug product should also include a summary (or full disclosure where required by law) of side effects, precautions, warnings and contraindications, and of effectiveness for the described uses. Such summary should have sufficent prominence in terms of type size, location, and similar factors to provide reasonable assurance that it will be observed.

3. Statements in promotional communications should be based upon substantial scientific evidence or other responsible medical opinion. Claims should not be stronger than such evidence warrants. Every effort should be made to avoid ambiguity. Whenever statistical or background information or references to unpublished literature or observations are used in promotional communications, the source material should be available to the medical profession upon request.

4. Statements with respect to or quotations from medical literature or from the personal communications of clinical investigators in promotional communications should not distort the intended meaning of the author or the significance of the study.

5. Any comparison with other drug products should be made upon a valid scientific basis.

6. No public communication by a manufacturer shall be made with the intent of promoting a drug product as safe and effective for any use before the required approval of the drug product for marketing for such use is obtained. However, this provision is not intended to abridge the right of the scientific community and the public to be fully informed concerning scientific and medical progress. Thus it is not intended to restrict a full and proper exchange of scientific information concerning a drug product, including appropriate dissemination of investigational findings in scientific or lay communications media, nor to restrict public disclosure to stockholders and others concerning any drug product as may be required or desirable under law, rule, or regulation.

7. Promotional communications should have medical clearance before their release.

B. Code Administration

It is the unqualified intent of the Association that each member shall follow strictly the principles set forth in the Code. To that end the members of the PMA are encouraged to submit information to the President with respect to any alleged breach of this Code by any other member. On the basis of such information and any other information available to him, the President shall take appropriate action including, if required, referral of the information to an ad hoc committee of the Board. The committee shall be chosen by the Chairman of the Board unless the member company represented by the Chairman has submitted such information or is the subject of such information, in which case the President shall make the appointments. The General Counsel of the Association shall act as secretary of each ad hoc committee and shall report the committee's findings to the President who in turn will refer the findings to the Board of Directors.

Any member firm which clearly and persistently violates the Code may be asked by the Board of Directors to resign from the Association.

Patronize Our Advertisers

The companies and places which advertise in this JOURNAL merit your support. The fact that their advertisements are here is assurance of their reputability. By placing these notices in these pages, they assist your JOURNAL and your Society.

Support Of JEMPAC

The American Medical Association calls attention to the resolution adopted by the 1967 AMA House of Delegates urging that leaders and members of local organizations continue support of their own state PAC organization as well as AMPAC.

The Medical Society of New Jersey gladly assumes leadership in this effort. Our Board of Trustees encourages individual physicians to join and support both JEMPAC and AMPAC. As recently as June 25, 1967, a conference committee with JEMPAC was appointed, whose purposes are to improve communication and exchange ideas.

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

(Listed in order of receipt)

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

GENERAL—Churchill L. Blakey, M.D., Tarboro Clinic, Tarboro, North Carolina 27886. University of Pennsylvania, 1963. Special interest, insurance and industrial medicine. Available November 1967.

INTERNAL MEDICINE—Jerome E. Block, M.D., 1601 Greycastle Avenue, Montebello, California. New Jersey College of Medicine, 1964. Solo or associate. Small town. Available July 1968.

Harvey I. Hurwitz, M.D., 33 Coleman Road, West Haven, Connecticut 06516. Boston University Medical School, 1962. Group. Available July 1968.

Alfred M. Derrow, M.D., 555 Wisteria Way, San Rafael, California 94903. Tufts 1962. Subspecialty, Renal Disease. Group. Available July 1968.

Seymour M. Cohen, M.D., 1565-A White Drive, Rantoul, Illinois 61866. University of Pittsburgh School of Medicine, 1962. Board eligible. Sub-specialty, Hematology. Group or partnership. Available July 1968.

OBSTETRICS AND GYNECOLOGY — David M. Margulies, M.D. 69 Euclid Road, Fort Lee, New Jersey. Northwestern University Medical School, 1961. Board certified. Available.

Arthur G. Aneckstein, M.D., 104A Jupiter Street, Sheppard AFB, Texas 76311. Tulane, 1961. Board eligible. Solo, partnership, or association. Available February 1968.

Kenneth E. Bell, M.D., 3175 B Lexington Street, Hill Air Force Base, Utah 84401. University of Buffalo School of Medicine, 1961. Board certified. Available June 1968.

Jerry Goosenberg, M.D., 75-B Yorktown Drive, Fort Lee, Virginia 23801. Jefferson, 1962. Board certified. Group. Available July 1968.

OPHTHALMOLOGY—M. Farooq Anwar, M.D., University Hospital, Birmingham, Alabama 35233. King Edward Medical College, Pakistan, 1960. Full time hospital staff. Available.

Harold J. Goldfarb, M.D., EENT Clinic, Womack Army Hospital, Fort Bragg, North Carolina 28307. Tufts, 1961. Board certified. Solo or associate in northern New Jersey. Available March 1968.

PEDIATRICS—Nathan Blinn, M.D., 1514 East Cliveden Street, Philadelphia, Pennsylvania. Jefferson Medical College, 1963. Solo or group. Available July 1968.

SURGERY — Lawrence B. Langsam, M.D. 1707 Terry Avenue, Bellevue, Nebraska 68005. Downstate Medical Center, 1960. Board certified. Group or partnership. Available.

A. Allen Badri, M.D., 6315 North Rosebury, Clayton, Missouri 63105. University of Teheran Medical School, 1959. General and plastic. Available.

Dennis M. Wadler, M.D., 245 East 25th Street, New York, New York 10010. Jefferson, 1961. Board eligible. Associate or group. Available July 1968.

Morton H. Goldstein, M.D., 3411 Wayne Avenue, Bronx, New York 10467. University of Chicago Medical, 1959. Board certified. Plastic. Available summer 1968.

Martin Winick, M.D., 800 Victory Boulevard, Staten Island, New York. Downstate Medical Center, 1960. Board certified. Pediatric. Available July 1968.

Donald A. Sugar, M.D., 5 Wheeler Place, Fort Stewart, Georgia 31313. New York Medical, 1961. Board — part I. Group or solo. Available May 1968.

Peter E. Downs, M.D., Fitzsimons General Hospital, Denver, Colorado 80240. Cornell Medical, 1957. Board certified. Multispecialty, group, partnership, or solo. Available.

UROLOGY—Alessandro Colalillo, M.D., 570 Mt. Prospect Avenue, Newark, New Jersey. University of Naples, Italy, 1955. Partnership or association with multispecialty group. Available.

Raymond D. Panetta, M.D., 632 Massachusetts Avenue, Riveride, California 92507. Georgetown, 1959. Board eligible. Group, partnership, or solo. Available June 1968.

ANNOUNCEMENTS

Nursing Research Fellowships

Fellowships to train nurses for research careers are now available from the Bureau of Health Manpower, United States Public Health Service. Nurses who hope to begin their research training within the next 12 months, and who need fellowship aid for this purpose, should submit their applications now. Nurses who aspire to careers in nursing research and who wish to apply for Special Nurse Fellowships should bear in mind that fellowship evaluation panels meet three times a year, and that it takes three to six months to process applications and announce awards. They, therefore, should be guided by the following timetable:

Applications received by:	*Awards announced by:*
January 2, 1968	June 1968
April 1, 1968	October 1968

Nurses who are planning a research career will be interested in a new brochure on eligibility requirements for Special Nurse Research Fellowships. For this brochure, also for application kits and other information, write the Division of Nursing, United States Public Health Service, 800 North Quincy Street, Arlington, Virginia 22203.

Conference on Prematurity

A Conference on Prematurity, sponsored by the AMA, will be held January 11-13, 1968 at Ft. Lauderdale, Florida. You are cordially invited to attend.

The program has been planned around three sessions to explore the problems of prematurity in depth with emphasis on obstetrical prevention and pediatric intervention. International speakers will discuss patterns of prematurity, mortality and morbidity factors, pathogenic implications, and national and international newborn programs. For more information, write to Committee on Maternal and Child Care, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Vector-Cardiography Course

The Beth Israel Hospital in Newark announces a course in basic vector-cardiography by Edwin L. Rothfeld, M.D., of the Newark Beth Israel Hospital Institute. The course will be held in Newark on five consecutive Monday evenings from 8 to 10 p.m. (January 15, 22, 29, February 5, and 12, 1968). You are welcome. For more details, write to Dr. Sol Parent, Beth Israel Hospital, 201 Lyons Avenue, Newark.

Workshop In Medical Writing

To make physicians more aware of problems in written communications, the AMA invites you to a workshop in medical writing, a five-day course from Monday, January 29, through Friday, February 2, 1968. Martin Ware, M.D., editor of the *British Medical Journal,* will be one of the "faculty" of three.

The course is for physicians only. Enrollment will be strictly limited to twelve. Since this workshop will center around problems of medical editors as well as writers, we will give first preference to physicians who perform some type of editorial function. The course is conducted through seminar-type meetings, holding three two-hour sessions each day with study assignments to fill in the "spare time." The group will meet at the AMA headquarters in Chicago.

There is no charge for the course other than a nominal $10 registration fee. Those who wish to apply should send, with their letter of application, a detailed curriculum vitae. Write to Lester S. King, M.D., at 535 North Dearborn Street, Chicago 60610.

Ophthalmology Conference

The Twentieth Annual Clinical Conference of the Wills Eye Hospital will be held on February 8, 9 and 10 (1968) at the Bellevue Stratford Hotel, Broad and Walnut Streets, Philadelphia, Pennsylvania. The Arthur J. Bedell Lecture will be given by Dr. G. Meyer-Schwickerath of Essen, Germany.

Inquiries should be addressed to Dr. Albert F. Cleveland, Wills Eye Hospital, 1601 Spring Garden Street, Philadelphia, Pennsylvania 19130.

Cancer Of The Oral Regions

The New Jersey State Dental Society, in cooperation with the New Jersey Department of Health, The Medical Society of New Jersey, Monmouth Medical Center, and Fairleigh Dickinson University, announces the fifth session of the Post Graduate Course, "Cancer of the Oral Regions," to be presented on four Wednesdays, April 17 and 24 and May 1 and 8, from 9 a.m. to 5 p.m. at Monmouth Medical Center, Long Branch, New Jersey.

The course stresses early detection of neoplastic lesions of the head, mouth, and neck. Emphasis is placed on the role of the general practitioner in the detection of tumors of the oral regions. The following will be covered in detail: etiology and epidemiology of oral cancer, pre-cancerous lesions, clinical and pathological diagnosis of oral cancer and related lesions. Exfoliative cytology and biopsy technics will be presented in lectures, demonstrations, and clinical practice.

A discussion of the problems of differential diagnosis of jaw lesions is planned. Odontogenic tumors, salivary gland tumors, neoplastic lesions of the larynx, pharynx, paranasal sinuses and neck will be covered. A one-day symposium on the present-day management of head and neck cancer will conclude the course.

Nationally known guest lecturers will participate in the presentation of the course. Enrollment is limited. No tuition is charged. Attendance is open to New Jersey physicians and dentists. The course is supported by the Cancer Control Program of the Public Health Service.

For information and registration, write to: Chairman, Department of Pathology, School of Dentistry, Fairleigh Dickinson University, 1000 River Road, Teaneck, New Jersey 07666.

Brochure On Hypertension And Heart Disease

The United States Public Health Service announces the availability of a 43-page brochure including three views of hypertension and heart disease. This paperback reviews examination methods and referral technics in hypertension and heart disease, and gives information on the validity and accuracy of data obtained from history-taking and examination. For your copy write to the Superintendent of Documents, United State Government Printing Office, Washington, 20402, and request Public Health Service Publication 1000-2-22. The price is 35¢

Baby Book Available For Educational Use

After selling more than 20 million copies, the well-known Spock volume, *Baby And Child Care,* is now available for educational distribution to hospitals and medical groups. Discount costs bring the price per copy down to somewhere between 26 and 42 cents. This includes an imprint of the distributing hospital or group on the back cover. For further details write to the Benjamin Company, Inc., 485 Madison Avenue, New York, New York 10022.

Abstracts On Juvenile Epilepsy

You may obtain an 82-page booklet which summarizes a number of recent articles dealing with epilepsy in children: etiology and classification, behavioral therapy, psychological evaluation, education, services, and behavior. This work was supported in part by the U.S. Department of Health, Education, and Welfare, and the reprint was through the courtesy of Parke, Davis and Company. The Epilepsy Foundation is located at 1419 H Street, NW, Washington, D.C. 20005.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1967
December

12 **Bergen County Medical Society**

12 **Cumberland County Medical Society**

13 **Gloucester County Tuberculosis and Health Association**

13 **Ocean County Medical Society**

13 **Princeton Hospital and Rutgers University School of Medicine**
Princeton
"New Concepts Regarding Digitalis"

13 **The Academy of Medicine of New Jersey**
Cherry Hill Inn
Symposium on Trauma

14 **Burlington County Medical Society**
Scientific/Business

20 **Middlesex County Medical Society**

21 **Morris County Medical Society**

21 **Gloucester County Medical Society**

27 **Princeton Hospital**
Princeton
"Metabolic and Pharmacologic Aspects of Alcoholism"

1968
January

2 **Hudson County Medical Society**
"The Problem of Persistent Viral Hepatitis"

9 **The Academy of Medicine of New Jersey, Section on Dentistry**
Fairleigh Dickinson University School of Dentistry, Teaneck

9 **Bergen County Medical Society**

10 **Camden County Medical Society**
"Current Medical Research with Immediate Clinical Significance"

10 **Princeton Hospital and Rutgers University School of Medicine**
Princeton
"Clinical Applications of New Concepts of Kinetics of Neutophilic Leukocytes"

10 **Ocean County Medical Society**

10 **Gloucester County Tuberculosis and Health Association**

11 **Essex County Medical Society**

17 **Middlesex County Medical Society**

17 **The Academy of Medicine of New Jersey**
Morristown Memorial Hospital
Symposium — "Acute and Chronic Care of the Alcoholic"

18 **Morris County Medical Society**

18 **Gloucester County Medical Society**

20 **Industrial Medical Association of New Jersey**
The Pines, Metuchen
Annual Dinner-Dance

24 **Saint Elizabeth Hospital**
Elizabeth
"Family Life"

30 **Cape May County Medical Society**

31 **Essex County Heart Association and Academy of Medicine**
Mutual Benefit Life Insurance Company, Newark
"Operable Heart Disease"

February

6 **Hudson County Medical Society**
"Models of the Heart in Electrocardiography"

13 **Bergen County Medical Society**

13 **Cumberland County Medical Society**

14 **Gloucester County Tuberculosis and Health Association**

14 **Ocean County Medical Society**

14 **Princeton Hospital and Rutgers University School of Medicine**
Princeton
"Somatic Aspects of Depression"

15 **Morris County Medical Society**

15 **Gloucester County Medical Society**

20 **Warren County Medical Society**

21 **Middlesex County Medical Society**

21 **The Academy of Medicine of New Jersey**
Robert Treat Hotel, Newark
Pediatric Symposium

28 **The Academy of Medicine of New Jersey**
Princeton Hospital, Princeton
Symposium — "Problems of Oral Contraceptives"

28 **New Jersey Gastroenterological Society**
Essex House, Newark

March

6 **Camden County Medical Society**
Ladies night — "Family Life Education"

6-9 **New Jersey Academy of General Practice**
Atlantic City

7 **Hudson County Medical Society**
"Current Trends in Medical Malpractice Litigation"

7-8 **The Academy of Medicine of New Jersey**
Newark City Hospital
Workshop on Culdoscopy

12 **Bergen County Medical Society**

12 **Essex County Medical Society**
Hotel Suburban, East Orange
"What Can An Office Consultant Do For You?"

13 **Princeton Hospital and Rutgers University School of Medicine**
Princeton
"Islet Cell Tumors of the Pancreas and Syndromes Associated With Them"

13 **Ocean County Medical Society**

13 **Gloucester County Tuberculosis and Health Association**

13 **The Academy of Medicine of New Jersey**
Mountainside Hospital, Montclair
Symposium on Supraventricular Arrhythmias

19 **Passaic County Heart Association**
Annual Meyer Notkin Lecture

20 **Middlesex County Medical Society**

21 **Morris County Medical Society**

23 **New Jersey State Society of Anesthesiologists**
Cherry Hill Inn, Cherry Hill
9th Annual Postgraduate Seminar

26 **Cape May County Medical Society**

27 **New Jersey Heart Association**

April

2 **Hudson County Medical Society**
"Some Psychiatric Problems of Childhood and Adolescence"

9 **Bergen County Medical Society**

9 **Cumberland County Medical Society**

10 **Ocean County Medical Society**

10 **Princeton Hospital and Rutgers University School of Medicine**
Princeton
"Biochemical Pharmacology And The Brain"

10 **Gloucester County Tuberculosis and Health Association**

16 **Warren County Medical Society**

17 **Middlesex County Medical Society**

18 **Morris County Medical Society**

18 **Gloucester County Medical Society**

24 **The Academy of Medicine of New Jersey**
Veterans' Administration Hospital
East Orange
Dental Symposium — "Periodontal Disease-Etiology and Treatment"

May

1 **Camden County Medical Society**

1 **Passaic County Heart Association**
Symposium on New Concepts in Cardio-Vascular Disease

7 **Hudson County Medical Society**
Election of Officers

8 **Princeton Hospital and Rutgers University School of Medicine**
Princeton
"Drugs, Poisons, and Membrane Phenomena"

8 **Ocean County Medical Society**

8 **Gloucester County Tuberculosis and Health Association**

9 **Essex County Medical Society**

14 **Bergen County Medical Society**

16 **Morris County Medical Society**

16 **Gloucester County Medical Society**

18-22 **The Medical Society of New Jersey**
Haddon Hall, Atlantic City
Annual Meeting

19 **The Academy of Medicine of New Jersey and The Medical Society of New Jersey**
Haddon Hall, Atlantic City
Symposium on Medicine and Religion

22 **Middlesex County Medical Society**

28 **Cape May County Medical Society**

June

6-7 **The Academy of Medicine of New Jersey**
Newark City Hospital
Workshop on Culdoscopy

11 **Cumberland County Medical Society**

12 **Gloucester County Tuberculosis and Health Association**

OBITUARY

Dr. Melvin M. Hunt

One of Middlesex County's senior physicians passed from the scene on October 13, 1967, with the death that day of Dr. Melvin M. Hunt. Dr. Hunt was born in 1889, when Benjamin Harrison was President of the United States. He earned his M.D. at the Jefferson Medical College in 1915. He interned at St. Barnabas Hospital, which in those days, was in Newark. Dr. Hunt was a general practitioner and proud of it.

For most of his professional life, he maintained his office in South River. He was one of the founders of the Rotary Club in South River, and, appropriately to his name, he was an interested and skillful hunter and rifleman, a winner of many National Rifle Association awards. He was active in the affairs of our Middlesex County Medical Society. Dr. Hunt was affiliated with the South Amboy Memorial Hospital, as well as with both hospitals in New Brunswick.

LETTER TO THE JOURNAL

Blithe Editor

Dear Sir:

I wish to take objection to some of the statements that you made in your editorial called "Hospitals, Medical Schools, and the GP," in the October 1967 issue *The Journal.* You state that one factor causing general practice to be unattractive is that if the G.P. sees a large number of patients he has to short change some of them. I think that any GP with any degree of conscience doesn't really do this. You state that in the layman's mind as soon as something gets too difficult, a specialist is summoned and this degrades the GP in the eyes of the public. Nothing could be further from the truth, most patients have confidence in the GP and feel that if he calls in a specialist they are grateful because he is doing this and not because of any lack of knowledge on his part.

Further in your article you state that if a doctor's own family should get sick, whom do they call? You insinuate that most family doctors would rather have a specialist than a GP to treat their own family. In other words, you are assuming that the trend is for medical men to call in a specialist for their own family and that we are really downgrading ourselves. I personally have many doctors' families that I take care of, and I have been in general practice for twenty-eight years.

The GP is not a feeding station for specialists as you so blithely* put it. The GP of today is the backbone of the medical profession and no amount of editorializing will undermine the hard-working GP in the eyes of his loyal patients; the GP who is progressive, takes graduate courses, and is "on the ball."

The basic problem today in the medical schools is the lack of instruction in the clinical approach to medical problems and in the lack of teaching the art of medicine. As long as the research boys, who have no conception of how to deal with ordinary people, remain in charge of the medical schools, there will be no one around to teach the students the art of medicine.

Yours sincerely,
Murray Levin, M.D.

MSNJ Scientific Exhibits

Members of The Medical Society of New Jersey are invited to participate in the Scientific Exhibits at the 202nd Annual Meeting, May 18 to 22, 1968, Haddon Hall, Atlantic City. Exhibits will open at noon on Sunday, May 19, and close at noon on Wednesday, May 22. The hours on Monday and Tuesday will be from 9 a.m. to 5 p.m. Applications may be obtained from the Executive Offices in Trenton, Mrs. Marion Walton, Convention Manager.

1968-1969 Membership Directory

It is now time to begin preparation of the 1968-1969 *Membership Directory.* Within the next few weeks each member will receive a verification data sheet. All members listed in the 1966-1967 *Directory* will be supplied with exact copies of their current listings, and will be asked to verify or modify those listings. Members to be included in the *Directory* for the first time will be asked to supply complete data.

Your cooperation is earnestly solicited. Accurate and complete data from you will help us to produce an accurate and complete *Directory.*

* *Your editor said it sadly, not blithely.*

BOOK REVIEWS

You Are as Young as Your Spine. Editha Hearn. Garden City, New York, 1967, Doubleday. Pp. 112. Illustrated. ($4.50)

Here is a small book of large print which can be read in a short period of time. It is intended for patients, not doctors. Miss Hearn is a physiotherapist of the school of Dr. James C. Cyriax of London, presently directing her own clinic in Brazil. Orthopedists, neurosurgeons, and general practitioners might wish to refer their patients to this publication as a prophylactic and therapeutic aid for spinal column mechanical disorders.

Miss Hearn illustrates and describes many exercises and postural attitudes to be recommended and/or avoided. She does a first rate job in this respect, but assumes more authority in diagnosis and dogma on the subject than most American physicians would be inclined to approve. She assigns all back conditions (and many others in the "rheumatic" category) to spinal disc pathology including the entire spine except for some 10 per cent of the cases. The latter, she acknowledges, may be of a more serious nature. "Rheumatism," she bluntly states, "is only another name for pain." She insists that the physiotherapist should "have access to any available X-rays, since these will often suggest where to look for complications during treatment." This assumption of professional know-how might be irritating to the medical or surgical specialist.

Miss Hearn demonstrates her own depth of training and experience even though, I am sure, most physiotherapists could not measure up to this standard. As an orthopedist, I feel that many patients with genuine mechanical low back complaints could be benefited by following the suggested exercise procedures outlined in this booklet. Many postoperative flail-backs might be avoided by close adherence to such a physical regimen. Recommend this to your patients with the limitations suggested.

JARVIS M. SMITH, M.D.

The Layman's Dictionary Of Psychiatry. J. A. Brassel, M.D. and George L. Cantzlaar. New York, 1967, Barnes & Noble. Pp. 269. (Paper back, $1.95; Clothbound, $4.50.)

From *abaissement* to *zoophobia*, the compilers present some 2500 definitions beamed at the literate non-psychiatrist. Some are definitions (Orientation), some refer to trade names ("Luminal"), some to people or organizations (Jung, London School), and some explain abbreviations (IMPS, OT). Many of the terms are so rarely used that one wonders if their inclusion was justified (osmolagnia, stasiphobia, zoanthropy, and so on). An appendix gives compact explanations of psychiatric problems like "accidents to patients" or "births to patients in institutions" or "alien patients returned to homeland" — items not usually thought of as dictionary entries. The book is a useful one for college students and even for beginning medical students. It is to be hoped it won't be used by patients for self-diagnosis or do-it-yourself analysis.

HENRY A. DAVIDSON, M.D.

Claude Barnard And Experimental Medicine. Edited by Francisco Grande and Maurice B. Visscher. Pp. 210. **The Cahier Rouge Of Claude Bernard.** Translated by Hebbel H. Hoff, Lucienne Guillemin and Roger Guillemin. Pp. 120. Cambridge, Massachusetts, 1967, Skenkman. ($8.95 — paperback, $4.95)

The publication of Bernard's "Introduction to the Study of Experimental Medicine" in 1865 was greeted by the French scientific world and the intelligentsia with a fervor matched only by the reception accorded to Osler's "Textbook of Medicine" (1892) in the United States. It took fifty years, at least, for us to realize its significance.

Thirteen authorities, in the first book of two, examine Bernard's contributions. Wagensten discusses Bernard's contributions to gastrointestinal physiology; Houssay reviews the concepts of Bernard on internal secretions. The great and original concept of *le milieu intérieur* is discussed by Holmes and Halberg.

The second of two-books-in-one is the first English translation of *Cahier Rouge*, a notebook of observations interpolated frequently with "why."

The editors in the difficult business of preventing repetition have done remarkably well. For those interested in the history of scientific medicine or the history of ideas this book is essential reading.

SIDNEY FRIEDENBERG, M.D.

The Office Assistant In Medical Practice. (Third Edition) Portia M. Frederick and Mary E. Kinn. Philadelphia, 1967, Saunders. Pp. 461. Illustrated. ($7.50)

This comprehensive textbook, in simple language, is an excellent guide for those training as medical assistants. It is also a superb reference book for those already so engaged. It provides a general orientation to the field of medical assistance and shows the relationship between various phases of the work. The text is divided into two sections: one encompasses business and secretarial skills, and the other deals with medical aspects. Here, in minute detail, is a description of every office procedure — from how to answer the telephone ("hold the instrument one inch from the lips, directly in front of teeth") to the essentials of bookkeeping and credit rating. Included are a concept of medico-legal aspects; a concise review of insurance programs — commercial, governmental, and voluntary; and a chapter devoted to essential personality qualifications. The young lady who masters this part of the text will be a paragon of the well-read, well-groomed, poised, charming, and efficient secretary!

The medical aspects of office procedure are well delineated. They include dealing with patients and assisting in examinations and therapy. There is much information to familiarize the medical assistant with the instruments used by physicians, the procedures and purposes of testing, and the uses and dangers of drugs. Also included is a brief discussion of professional organizations, keeping the physician's personal library, and the preparation of manuscripts. Three appendices list reference books for medical assistants, the commonly used abbreviations and symbols, and diagnostic laboratory procedures. Numerous excellent illustrations are included in both sections of the book.

There is much repetition. But, in view of the intended purpose as a textbook, perhaps this is good. This compilation will also be useful to the physician in training his office staff.

MARJORIE D. TREPTOW

An Atlas Of Fine Cell Structure: The Cell, Its Organelles And Inclusions. Don W. Fawcett, M.D. Philadelphia, 1966, Saunders. Pp. 448. Illustrated. ($11.00)

This photographic atlas consists of 259 electron micrographs showing the cellular ultrastructure of animal tissues and organs. They are arranged in three main sections: cell organelles, cell inclusions, and the cell surface. A concise descriptive text of the functional significance of the morphologic features faces each page of illustrations. The electron micrographs are outstanding in clarity and detail. Labeling (kept at a minimum to avoid confusion) is adequate and well-planned. While the author intended this text for the medical student, it should be equally useful to the practitioner in giving a well-integrated, modern understanding of the topographic relation of the ultrastructure of the cell to its functional significance.

Louisa P. Fanale, Ph.D.

Preoperative and Postoperative Care. American College of Surgeons. Philadelphia, 1967, Saunders. Pp. 506. ($8.50)

The American College of Surgeon's first manuals on *Fractures* and on the *Early Care of Soft Tissue Injuries* were recognized by practicing surgeons, teachers of surgery, and house officers as authoritative sources of practical information. The third and current manual, *Preoperative and Postoperative Care,* is precisely the same type of volume. The authors seek "to provide a useful outline for modern methods of handling major problems of preoperative preparation and postoperative management of patients under-going both elective and emergency surgery." For the practicing surgeon they succeed admirably.

This well organized book covers in 506 pages broad general principles of pre- and post-operative care and specific body systems and problems. The type is clear and there are many examples and illustrations. For a concise treatment of an important subject, this superior book will be useful to, and used by, all physicians treating surgical patients. Joseph J. Kinney, M.D.

Handbook of Orthopedic Surgery. A. R. Shands, M.D. and R. B. Raney, M.D., with the collaboration of H. R. Brashear, M.D. St. Louis, 1967, Mosby. Pp. 572. Illustrations. ($12.00)

The seventh edition of the *Handbook of Orthopedic Surgery* continues to present the fundamental facts and principles of orthopedic surgery in a concise form, yet with sufficient detail to convey a well rounded knowledge of the subject. There are no major changes in this seventh, as compared to previous editions of this well-known work. The only new additional subjects are brief sections on avascular necrosis of the femoral head, acquired spastic paralysis in adults, and traumatic paraplegia and quadriplegia. In addition, for the first time, median ulnar nerve injury, ochronosis, and chondrocalcinosis are included.

The book would be a valuable addition to the library of medical students, house officers, general practitioners, and other specialists, including pediatricians, who are not orthopedic surgeons. The orthopedic surgeon would benefit from this text, if he doesn't already have a previous edition on his shelf, by the generous and useful bibliography which is well organized and extends for 75 pages.

In this book, X-rays are reproduced as positives, as is the style in most British X-ray reproductions. Thus, the physician has to reorient himself in studying the X-rays.

Descriptive terminology of range of motion of the various joints follows the recommendations of the American Academy of Orthopedic Surgeons in their 1963 booklet *Measuring and Recording of Joint Motion*. General usage, however, dictates the need for explanation of such terms as "forward flexion," "backward flexion," and "elevation" with specific reference to the shoulder joint.

In summary, the *Handbook of Orthopedic Surgery* has previously established itself as a standard and has now gone on to become a classic in its field.

R. Theodore Nussdorf, M.D.

Respiratory Physiology. N. Balfour Slonim, M.D. and John L. Chapin, Ph.D. St. Louis, 1967, Mosby. Pp. 199. Illustrated. ($8.75)

This monograph explores respiratory physiology in twelve chapters, beginning with the basic laws of gas behavior and working toward the clinical evaluation of pulmonary function. It succeeds admirably in clarifying basic physical and physiologic processes and in showing how these relate to the process of respiration, from breathing to tissue oxygenation. It is less successful in its clinical aspects. There are no footnotes or direct references to the original sources of information and further articles about specific subjects which the interested student may want to explore further. The bibliography at the end of the book, is also unfortunately scanty.

After a brief introduction, the book proceeds in an orderly and clear presentation of physiologic phenomena in succeeding chapters. The tables, figures, and especially electron photomicrographs are excellent. The chapter on pH is particularly noteworthy, with an excellent discussion of hypokalemim metabolic alkalosis, a phenomenon little appreciated in clinical pulmonary situations. Only one chapter has a summary. Especially valuable for the medical student would be an outline at the beginning of each chapter, as well as a summary of the material presented.

The authors have attempted to condense into a compact volume much physiologic information. The material presented has value for the medical student. The interested clinician or advanced student must seek further texts for more information on this increasingly important subject. Ellis P. Singer, M.D.

Correction

The Journal wishes to call attention to an error in the price for individual books (4) of the 1966 International Psychiatry Clinics Series (Little, Brown and Company), reviewed on pages 588 and 589 of the October issue. The complete volume is $18.50, as listed; *single books are $8.50 each,* and not the price given in our review.

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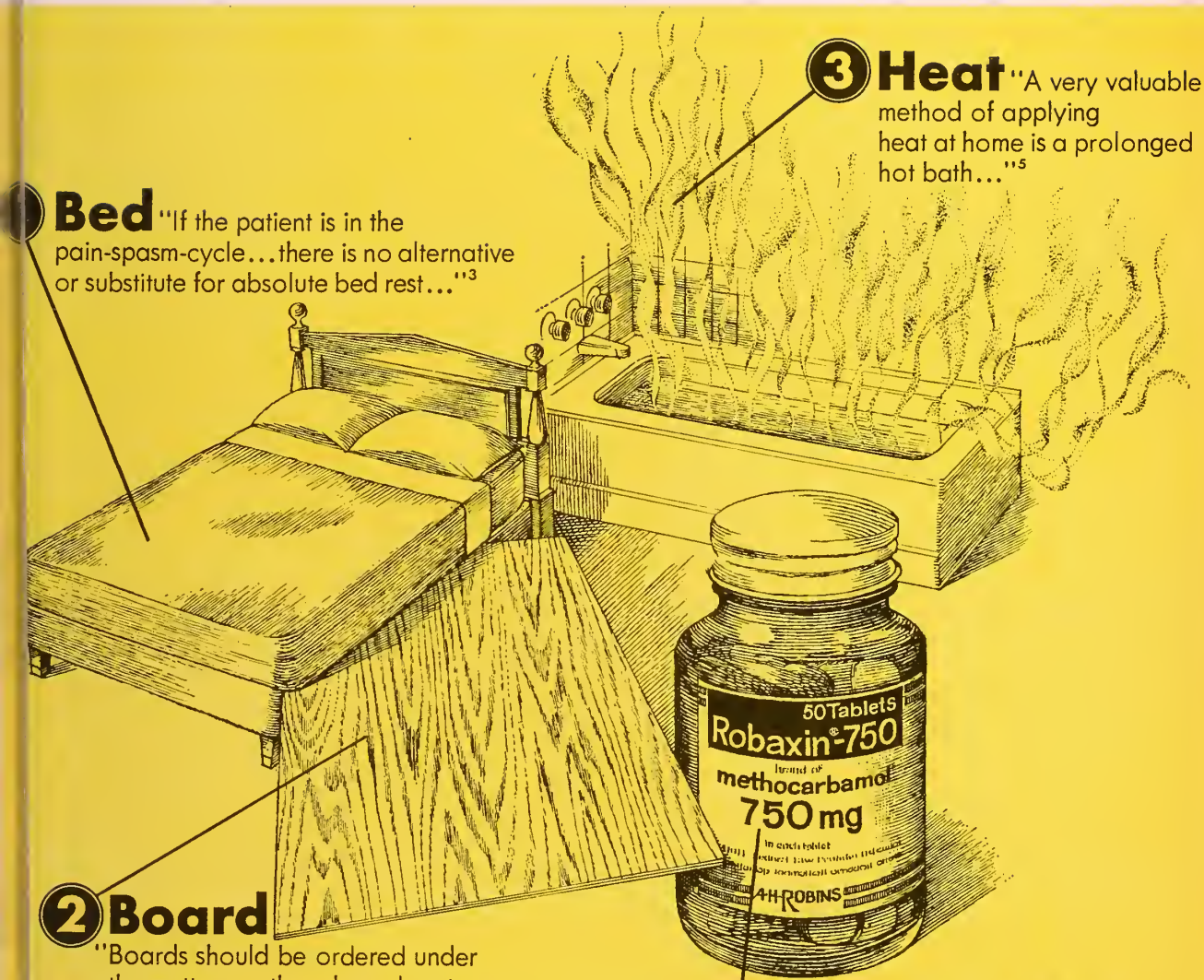
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LOW-BACK PAIN

A CONSERVATIVE, FOUR-POINT PROGRAM

The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.[1,2] For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:



1 Bed "If the patient is in the pain-spasm-cycle...there is no alternative or substitute for absolute bed rest..."[3]

2 Board "Boards should be ordered under the mattress...these boards act by immobilizing the spine..."[4]

3 Heat "A very valuable method of applying heat at home is a prolonged hot bath..."[5]

4 Robaxin®-750 (methocarbamol, 750 mg. capsule-shaped tablets) A well-tolerated[6] skeletal muscle relaxant, methocarbamol helps relieve spasm "...without interfering with normal tone and movement."[7] And there is little likelihood of sedation.[6]

ted for relief of skeletal muscle spasm. **Contraindicated in** ensitive patients. **Side Effects** (lightheadedness, dizziness, ness, nausea) may occur rarely, but usually disappear on reduced e. Hypersensitivity reactions develop infrequently. See product re for further details. **Also available:** Robaxin® Tablets carbamol, 500 mg.) Rabaxin Injectable (methocarbamol, 1 Gm./10 cc.)

nces: (1). Godfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gattschalk, P 33:91, 1966. (3). Rowe, M.L.: J. Occup. Med. 2:219, 1960. ozen, L.: South Dakota J. Med. 18:26, 1965. (5). Sota-Hall, R.: c. 14:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteopath. A. , 1962. (7). Feuer, S.G., *et al.*: New York J. Med. 62:1985, 1962.

A·H·ROBINS A. H. ROBINS COMPANY RICHMOND, VIRGINIA 23220



"Yes, Doctor, the pain is gone."

'EMPIRIN'® COMPOUND with CODEINE PHOSPHATE gr. 1/2 No. 3

Each tablet contains: Codeine Phosphate gr. ½ (Warning—May be habit forming), Phenacetin gr. 2½, Aspirin gr. 3½, Caffeine gr. ½.

■ Despite introduction of synthetic substitutes, efficacy of 'Empirin' Compound with Codeine remains unchallenged.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl®-1.

(norethindrone 1mg. & mestranol 0.05mg.)

Turn page for contraindications, precautions and side effects.



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Prescribing Information

Contraindications: Patients with any symptoms or history of thrombophlebitis, pulmonary embolism, liver dysfunction or disease, carcinoma of breast or genital organs, or undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. The safety of Norinyl-1 in pregnancy has not been demonstrated. If a patient misses two consecutive periods, pregnancy should be ruled out before continuing the medication. If she has not adhered to the prescribed schedule, pregnancy should be considered at the first missed period. Active ingredients of oral contraceptives have been detected in the milk of mothers who received these drugs; the significance to infants has not been determined.

Precautions: Pretreatment physical should include examination of the breasts and pelvic organs, as well as a Papanicolaou smear. If endocrine or liver function tests are abnormal during therapy, repeat tests are recommended after the drug has been withdrawn for two months. Following administration of drug, preexisting uterine fibromyomata may increase in size. Careful observation and caution are required for patients with symptoms or history of epilepsy, migraine, asthma, cardiac or renal dysfunction, cerebrovascular accident, psychic depression, and diabetes. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Possible long-term effects of the drug on pituitary, ovarian, adrenal, hepatic or uterine function must await further studies. The physician should be alert to the earliest manifestations of thrombophlebitis and pulmonary embolism. The drug should be used judiciously in those young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask symptoms of the climacteric. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following have been observed with varying inci in patients receiving oral contra tives: nausea, vomiting, gastroin tinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, ede chloasma or melasma, breast cha (tenderness, enlargement and secretion), change in weight (inc or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when gi immediately postpartum, cholest jaundice, migraine, rash (allergic rise in blood pressure in suscepti individuals, mental depression. Although the following side effe have been reported in users of or contraceptives, no cause and effe relationship has been established anovulation posttreatment, prem struallike syndrome, changes in libido, changes in appetite, cystit like syndrome, headache, nervou ness, dizziness, fatigue, backache hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, itching. The following occurrence have been observed in users of or contraceptives (a cause and effect relationship has neither been est lished nor disproved): thrombophlebitis, pulmonary embolism, neuroocular lesions.

The following laboratory tests m be altered by the use of oral contr ceptives: increased sulfobromoph thalein and other hepatic funct tests, coagulation tests (increase i prothrombin, factors VII, VIII, IX and X), thyroid function (increase PBI and butanol extractable prote bound iodine and decrease in T^3 values), metyrapone test, pregnanediol determination.

norethindrone — an original steroid from

SYNTEX

LABORATORIES INC., PALO ALTO, CALIF.

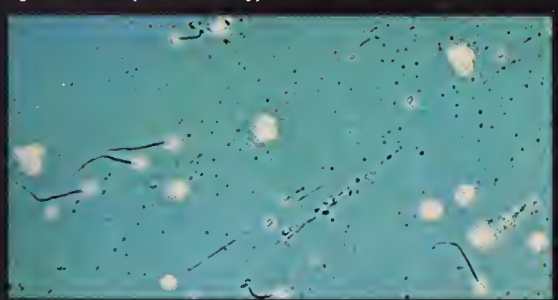
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

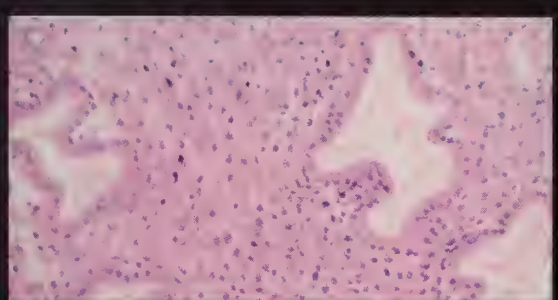
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.



Spermatozoa appear healthy, active, freemoving.

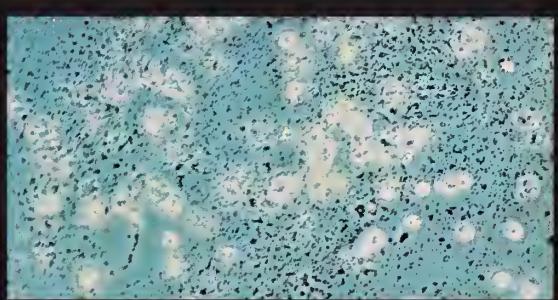


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

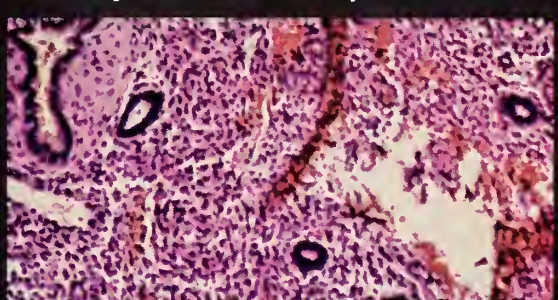
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



Norethindrone in Norinyl-1 accelerates secretory phase, suppresses glandular and vascular development.

Norinyl®-1
(norethindrone 1mg. ē mestranol 0.05mg.) tablets

- new low dose of time-proved ingredients
- established norethindrone/mestranol ratio
- lower patient cost

An uncommon steroid for common inflammatory dermatoses

In everyday topical steroid therapy, Synalar produces rapid resolution of inflammation and itching in steroid-responsive dermatoses—and at relatively low cost to the patient.

Advanced molecular design enhances potency

Synalar combines the advantage of earlier corticosteroid compounds with unique structural innovations. As a result, preparations of Synalar 0.01% and Synalar 0.025% have been reported to be more potent topically and significantly more effective than hydrocortisone 1.0%. The unique fluocinolone acetonide molecule provides one of the most useful topical corticosteroids for everyday practice.

Impressive clinical results in a wide range of dermatologic problems

The clinical efficacy of Synalar has been extensively documented in the world literature. Commonly encountered diseases such as allergic and contact dermatitis, eczematous and seborrheic dermatitis, and neurodermatitis respond rapidly to Synalar, often where previous therapy with other topical corticosteroids has failed.

Low patient cost for wider usefulness

With Synalar, a high degree of efficacy does not mean high price. And—a small quantity goes a long way. Thus, your patients can often obtain the "economy" of a hydrocortisone preparation with the proved efficacy of a potent, truly advanced steroid.

Synalar
fluocinolone acetonide





Turn page for contraindications, precautions and side effe

For everyday topical steroid therapy

Synalar® 0.01%

fluocinolone acetonide provides economy in two practical dosage forms

For general use, the most economical and widely applicable concentration of Synalar is 0.01% Cream in a water-washable, vanishing cream base. Synalar Solution 0.01% is especially valuable in dermatoses involving moist, intertriginous areas or hairy sites where creams and ointments do not spread or penetrate readily. Synalar Solution is a unique dosage form—clear, nongreasy, cosmetically elegant.

Product Information

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. *Precautions:* Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time. *Side Effects:* Side effects are uncommon with topical corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. In such cases the agent should be discontinued and appropriate measures taken. *Availability:* Synalar (fluocinolone acetonide) Cream 0.025%—5, 15 and 60 Gm. tubes and 425 Gm. jars. Cream 0.01%—15, 45 and 60 Gm. tubes and 120 Gm. jars. Solution 0.01%—20 and 60 cc. plastic squeeze bottles. Ointment 0.025%—15 and 60 Gm. tubes. Neo-Synalar® (neomycin sulfate 0.5% [0.35% neomycin base], fluocinolone acetonide 0.025%) Cream—5, 15 and 60 Gm. tubes.

fluocinolone acetonide—an original steroid from

SYNTEX LABORATORIES INC., PALO ALTO, CALIF



Before prescribing, see complete prescribing information in SK&F literature or *PDR.* A brief precautionary statement follows.
Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal obstruction, or bladder neck obstruction.
Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.
Usage in Pregnancy: Use cautiously, especially in the first trimester. *Note:* The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.
Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible side effects of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported but no causal relationship has been established.



a stuffy nose is no laughing matter

Ornade® Trademark

Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate), 50 mg. of phenylpropanolamine hydrochloride, and 2.5 mg. of isopropamide, as the iodide.

Spansule® Capsules

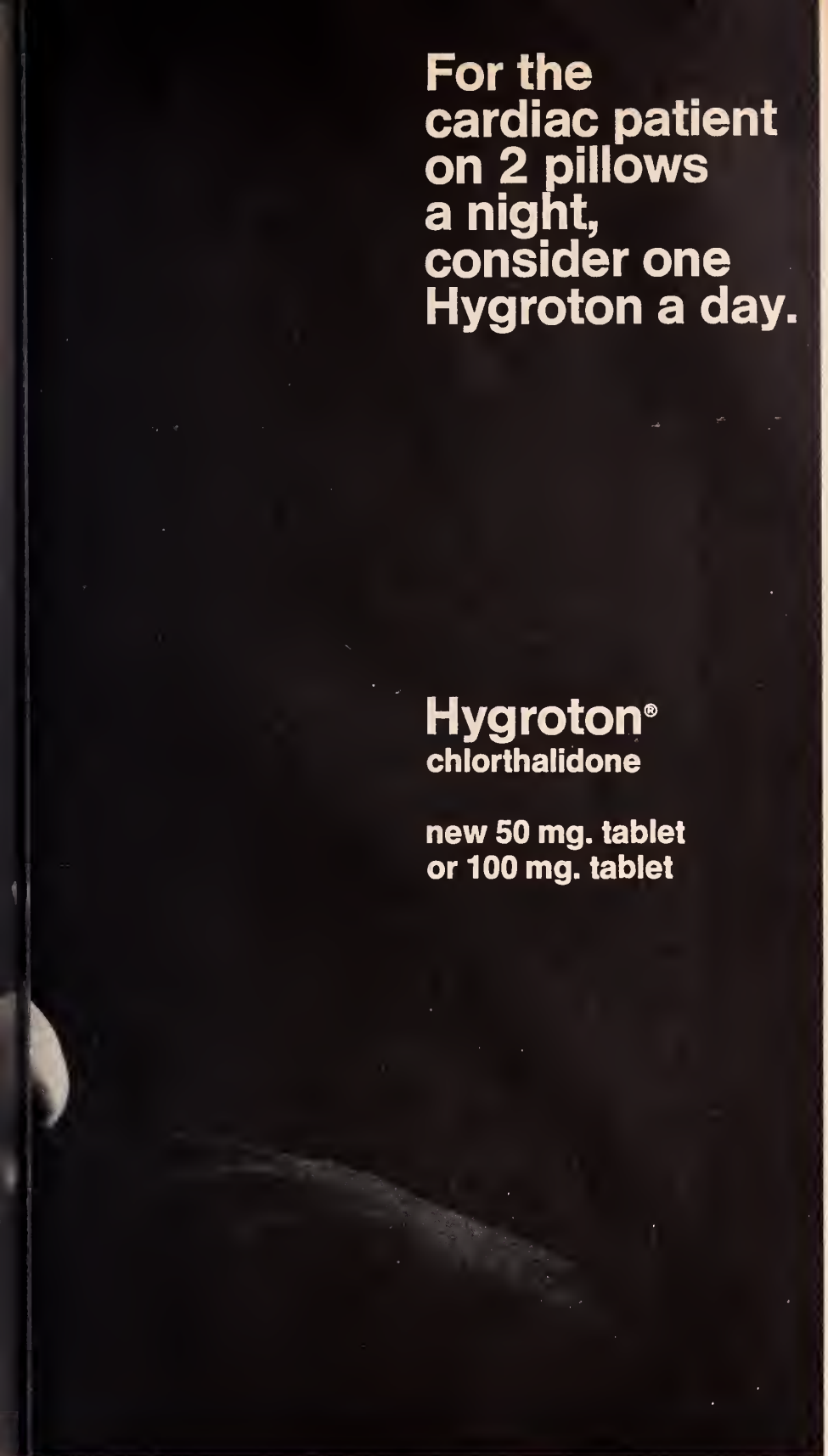
brand of sustained release capsules

each one can give him all-day or all-night relief

SK&F Smith Kline & French Laboratories



Indications: Hypertension and many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.
Use with caution in pregnant patients, since the drug may cross the placental barrier and adverse reactions which may occur in the adult (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.
Precautions: Antihypertensive therapy with Hygroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol may potentiate hypotension. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.
Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Hygroton should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.
Take special care in cirrhosis or



She was the picture of arteriosclerotic heart disease in failure.
She couldn't sleep a wink without an extra pillow.
Then her doctor prescribed digitalis and Hygroton.

First, her cardiac output improved.
Then her breathing improved—along with her urinary output.

Nights could be a lot more pleasant for patients like this in your practice.
Try it and see.

Hygroton therapy may also mean troublesome side effects for certain patients.
A summary of essential prescribing information is shown below.

evere ischemic heart disease and
n patients receiving corticoste-
oids, ACTH, or digitalis. Salt re-
riction is not recommended.
dverse Reactions: Nausea, gastric
ritation, vomiting, anorexia, con-
tipation and cramping, dizziness,
eakness, restlessness, hypergly-
emia, hyperuricemia, headache,
uscle cramps, orthostatic hypo-
nsion, aplastic anemia, leuko-
enia, thrombocytopenia, agranu-
cytosis, impotence, dysuria,
ansient myopia, skin rashes, urti-caria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.
Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.
Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.
(B)R46-230-D
For full details, please see the complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502
HY-5405S

If hypothyroidism leaves your patient feeling like this...

consider

LETTER®

(SODIUM LEVOTHYROXINE, ARMOUR) TABLETS

Synthetic Thyroid Replacement Therapy



Letter® provides all the advantages of the synthetically pure chemical sodium levothyroxine. Dosage is precise and potency is consistently uniform.

and

Letter® is micronized to provide maximum opportunity for full absorption and clinical response.

In addition Letter® is distinctively color coded with an identifying number stamped on each tablet to provide accurate dosage control.

Indications: Hypothyroid conditions. **Contraindications:** Thyrotoxicosis, acute myocardial infarctions unless associated with hypothyroidism. In hypothyroidism with hypoadrenalism coadministration of corticoids with LETTER® is recommended. **Precautions and Side Effects:** Excessive dosage may result in diarrhea, cramps, palpitation, nervousness, rapid pulse, sweating. If symptoms appear, discontinue medication for several days, then reinstitute at a lower level. Since myxedema patients with heart disease may suffer seriously from abrupt increases in dosage, caution should be exercised in adjusting dosage. **Dosage:** Generally, the initial adult dosage is 0.1 mg. daily. This may be increased in small increments every one to three weeks until proper metabolic balance is achieved. **Available:** Bottles of 100 tablets, in six potencies: 0.025 mg. (violet), 0.05 mg. (peach), 0.1 mg. (pink), 0.2 mg. (green), 0.3 mg. (yellow), and 0.5 mg. (white).

ARMOUR PHARMACEUTICAL COMPANY • CHICAGO, ILLINOIS



after surgery

B and C vitamins are therapy: Therapeutic amounts of B and C in stress formula vitamins often are vital during periods of physiologic stress. STRESSCAPS capsules, designed to meet increased metabolic demands, aid in achieving a more comfortable convalescence, a more rapid recovery. After surgery, as in many stress conditions, STRESSCAPS vitamins are therapy.



Stresscaps®

Stress Formula Vitamins Lederle

FOR PROFESSIONAL RECOMMENDATION ONLY

Each capsule contains:

Vitamin B_1 (Thiamine Mononitrate)	10 mg
Vitamin B_2 (Riboflavin)	10 mg
Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Vitamin C (Ascorbic Acid)	300 mg
Niacinamide	100 mg
Calcium Pantothenate	20 mg

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

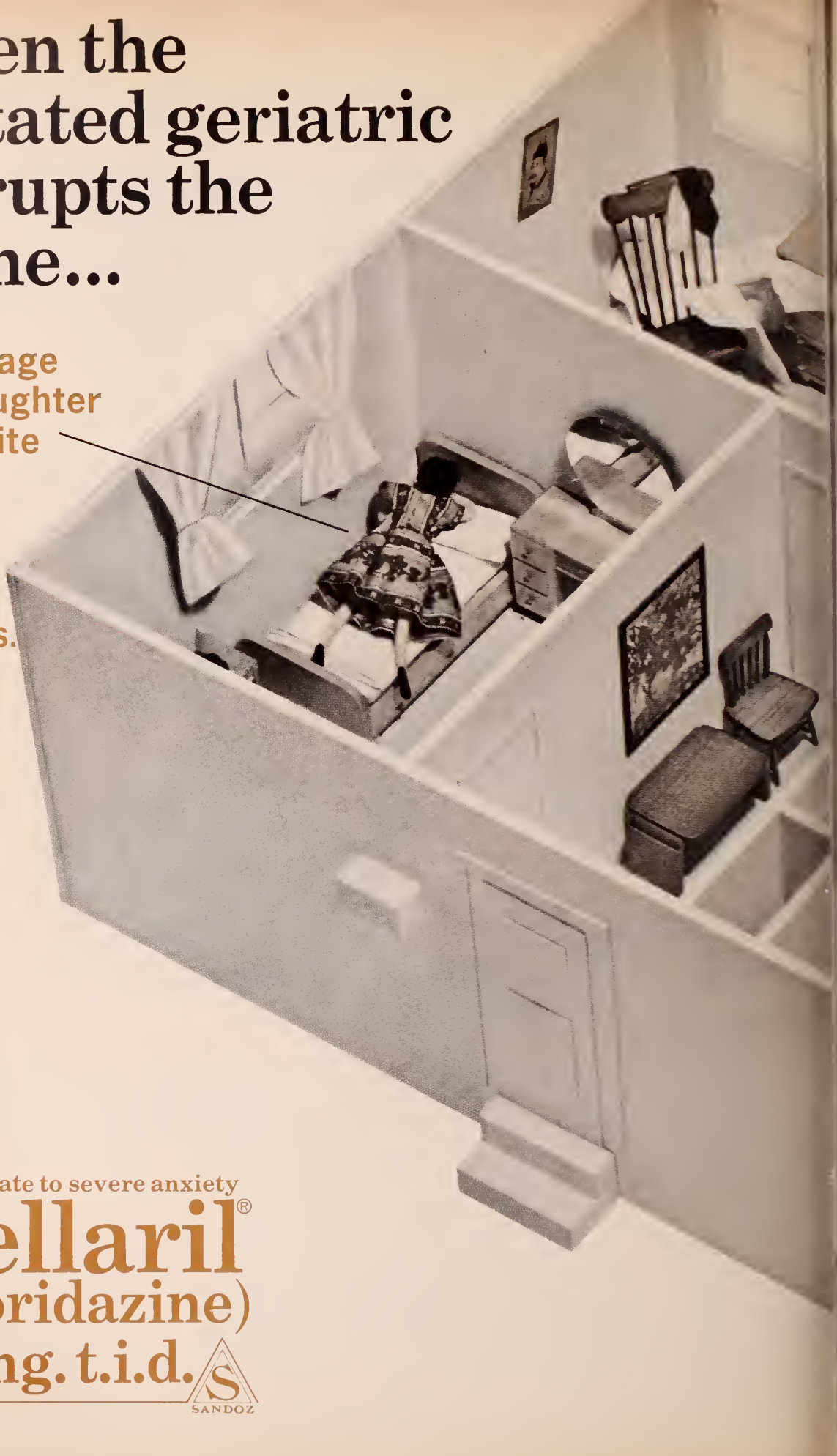
LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

Lederle

627-6—3613

When the agitated geriatric disrupts the home...

His teen-age granddaughter won't invite friends home because of his outbursts.



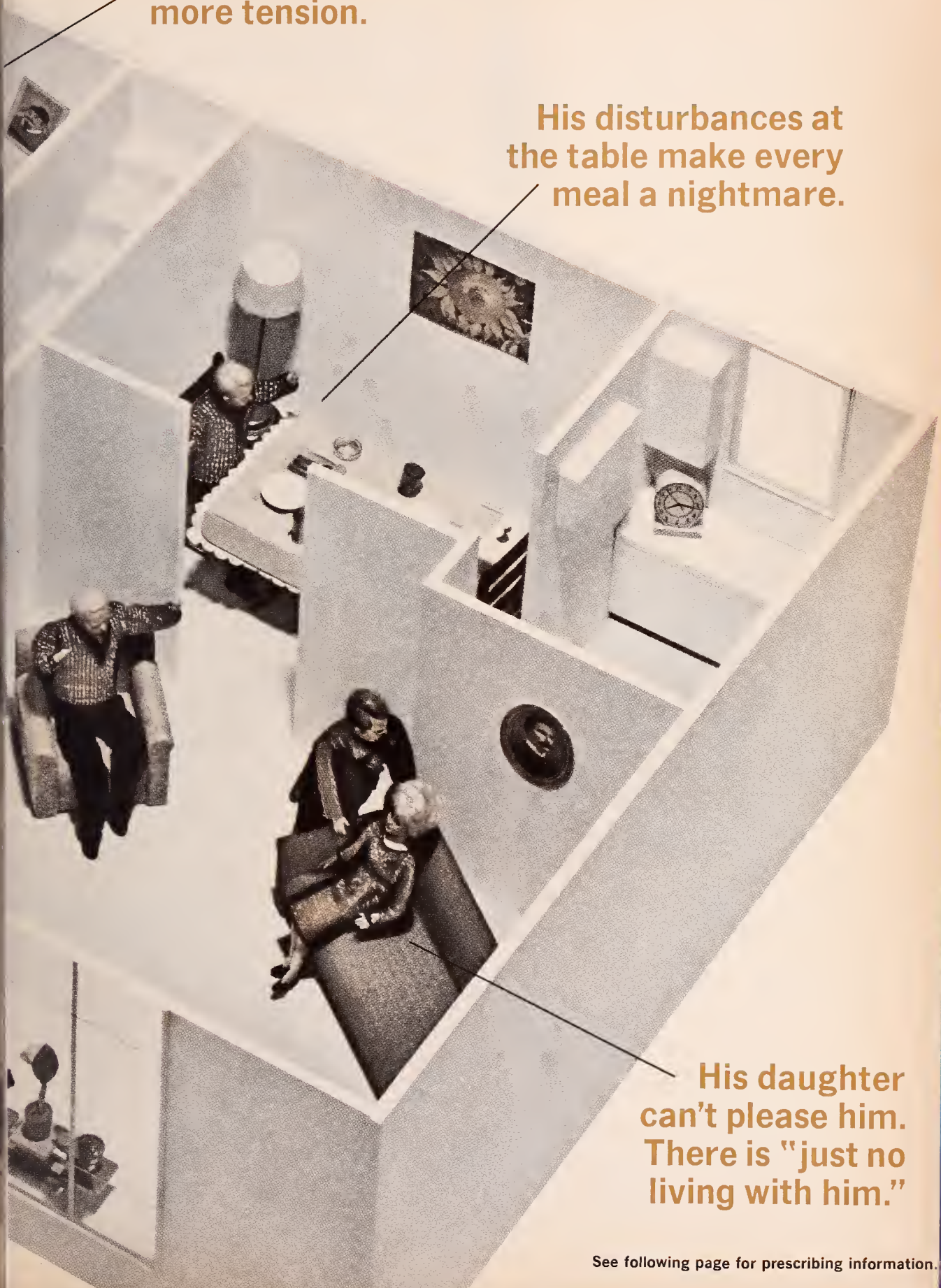
for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.

SANDOZ

His slovenly room and habits create more tension.

His disturbances at the table make every meal a nightmare.



His daughter can't please him. There is "just no living with him."

See following page for prescribing information.

When the agitated geriatric disrupts the home...

Anxiety that *seriously interferes* with the individual's performance at work, at home, or in the community may be regarded as *moderate* to severe in degree.

Mellaril often recommends itself to the treatment of moderate to severe anxiety because it

- helps control the most frequent symptoms: marked tension, agitation, apprehension, restlessness, hypermotility
- often alleviates anxiety-induced somatic complaints
- frequently helps strengthen emotional resources
- helps the patient maintain realistic contact with environment, closer harmony with family

Thus, when you consider the anxiety moderate to severe...consider Mellaril.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

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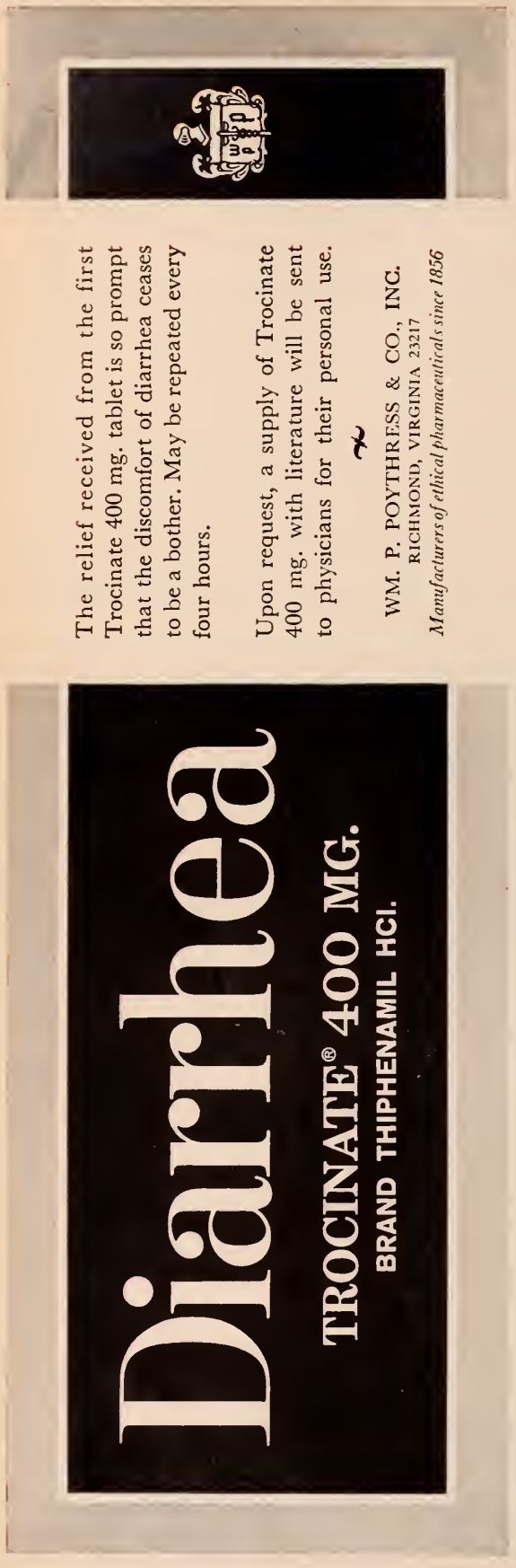
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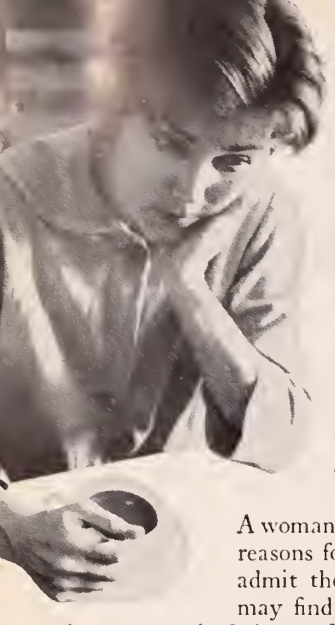
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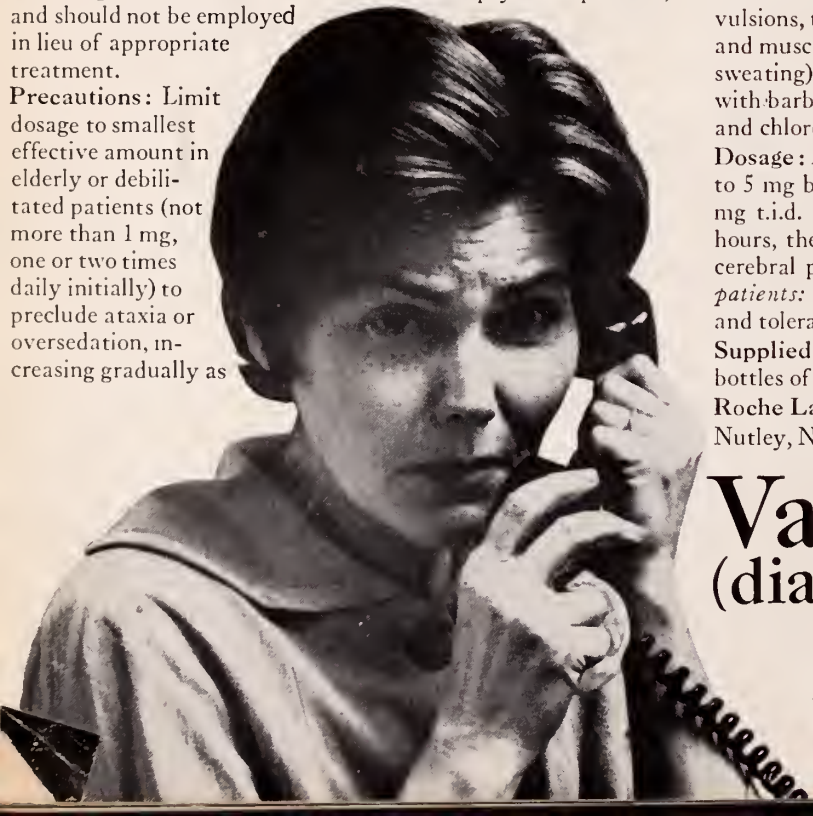


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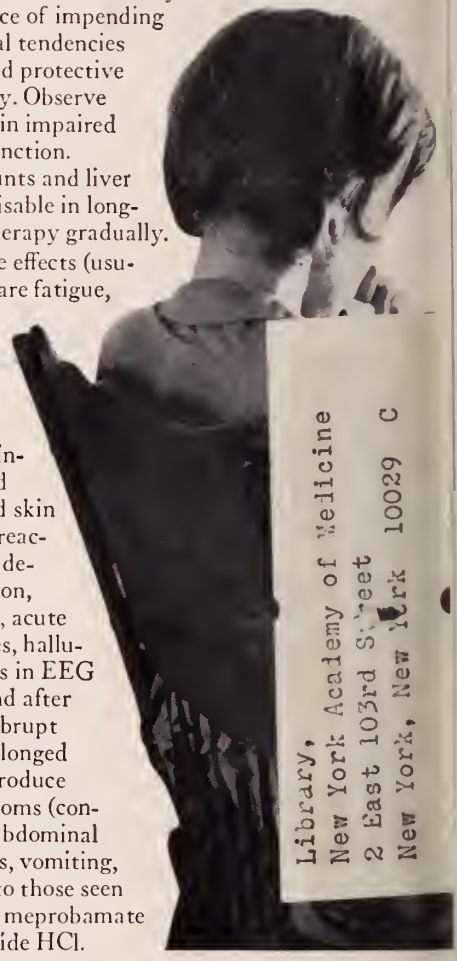
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Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances, acute hyperexcited states, hallucinations); changes in EEG patterns during and after drug treatment. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms (convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.



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